University of Iowa Fetal Cardiology Referral Form

PATIENT NAME *(last, first, M.I):*		
Maiden name:	DOB:	SSN
Interpreter ☐ Yes - If yes, language:	☐ No	
Patient address:		
Patient preferred phone:	Emergency contact:	
Patient e-mail address:		
Required Primary Insurance carrier (plan name):		
Name of policy holder:		
Policy ID #:	ID#:	Relationship to insured:

Referring physician:	Office contact person:
Office phone #:	Office fax #:
Primary obstetrician, if not referring physician:	

Preferred scan location: ☐ UIHC Hospitals and Clinics ☐ UIHC Quad Cities Outreach	
FETAL CARDIOLOGY	Indication for referral (DX):
☐Fetal MRI ☐Fetal Ultrasound ☐Fetal Echo w/ consult ☐Maternal Fetal Medicine ☐Transfer of care (pending approval) ☐Congenital Cardiothoracic Surgery ☐Genetics	

OBSTETRIC ULTRASOUND	LMP:	EDD:	EDD based on LMP/Ultrasound/Other:
Number of fetuses:			G/P

Please fax required documents prior to scheduling to: 319-384-6955

☐ This form ☐ Insurance card (front and back) ☐ Medical records (prenatal record, all labs, ultrasounds, c/s operative report) If no response within 48 hours, please call 319-356-3538.