# University of Iowa Maternal Fetal Medicine

**Please fax required documents prior to scheduling to: 319-356-7556**

* 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 319-356-8892*

**REFERRAL ORDER FORM**

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| **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\**** Insurance name (plan name): |
| Name of policy holder: |
| Policy ID #: | ID#: | Relationship to insured: |

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

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| Preferred scan location:  UIHC Hospitals and Clinics  UIHC Quad Cities Outreach  UIHC Cedar Rapids Outreach  UIHC Burlington Outreach  UIHC Muscatine Outreach  |
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| **MATERNAL-FETAL MEDICINE** | Indication for referral (DX): |
| * Maternal pre-pregnancy consult  High-Risk OB consult (maternal complication only)  Shared Care

 Transfer of care  Delivery at UIHC  Fetal care (fetal complication only)  |

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| **OBSTETRIC ULTRASOUND** | LMP: | EDD: | EDD based on LMP/Ultrasound/Other: |
| Number of fetuses: | G/P |
| * Nuchal Translucency (11-13.6 weeks)
* Level II Fetal Diagnosis Ultrasound

 Suspected Maternal Condition (placental or cervical complication, obesity, AMA)  Suspected Fetal Condition* Follow Up Level II Fetal Diagnosis Ultrasound: growth (re-evaluation fetal size and/or re-examination of specific organs(s) known or suspected to be abnormal)
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**DIAGNOSTIC TESTING**  Amniocentesis (greater than 16.0 weeks)  CVS (10–13.6 weeks)

*\* Blood type is required.*

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| **GENETIC COUNSELING**   Pre-conception counseling  Clinically recommended/medically necessary  Elective Referral  |