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Houston Center for Maternal Fetal Medicine
an affiliate of MEDNAX

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TODAY'S DATE:_____

PATIENT: _____DOB: _____ SSN: _____

ADDRESS: _____ CITY: _____ ZIP: _____

PHONE #: _____ ALT #: _____ EMAIL: _____

INSURANCE: _____ ID#: _____ GROUP #: _____

POLICY HOLDER: _____ DOB: _____ RELATIONSHIP TO PT: _____

REFERRING PROVIDER: _____ NPI# _____

PHONE: _____ FAX: _____ CONTACT:_____

REQUIRED	**Level of Participation:** ❒ **ONE TIME VISIT FOR CONSULTATION & MANAGEMENT PLAN** ❒ **CONSULTATION WITH SUBSEQUENT OUTPATIENT VISITS (CO-MANAGEMENT)** ❒ **TRANSFER OF CARE** **LMP: _____ EDD: _____ G: ___ P: ___ BLOOD TYPE: _____ ANTIBODY SCREEN: _____** **Does your patient require an interpreter**? ❒ YES ❒ NO **If YES, language spoken: _____**

❒ **FIRST TRIMESTER SCREENING:** Includes pre-test counseling, NT US and lab work. If abnormal, genetic counseling, detailed ultrasound, and additional testing will be offered.
If screening is normal, do you want patient to return for detailed ultrasound at 18-20 weeks? ❒ YES ❒ NO

1ST TRIMESTER ULTRASOUND: Consultation and management plan provided, if indicated by US findings
❒ Bleeding
❒ Size/Date Discrepancy
❒ Suspected ectopic
❒ Other: _____

2ND/3RD TRIMESTER ULTRASOUND: Consultation and management plan provided, if indicated by US findings
❒ Screen for malformations, Anatomy scan
❒ Size/Date Discrepancy
❒ Bleeding
❒ Fibroids
❒ Multiple Gestation, # of fetuses _____
❒ Known/Suspected Fetal Abnormality: _____
❒ Known/Suspected Placental Abnormality
❒ Known/Suspected Polyhydramnios or Oligohydramnios
❒ Known/Suspected Cervical Abnormality
❒ Biophysical profile (BPP)
❒ NST
❒ Other: _____

FETAL ECHO:
❒ Known/Suspected Fetal Arrhythmia
❒ Family history of cardiac condition
❒ IVF
❒ Other: _____

GENETIC COUNSELING: Includes detailed family history, US (if indicated) and management plan.
❒ NO Aneuploidy screening ❒ NO Carrier screening
❒ ABNORMAL NIPT, QUAD, 1st TM Screen **Please fax ALL results**
❒ ABNORMAL Carrier Screening **Please fax ALL results**
❒ Advanced Maternal Age
❒ Family history: _____
❒ Previous pregnancy/child with: _____
❒ Teratogen exposure: _____
❒ Preconception
❒ Other: _____

PERICONSULT: Includes detailed patient history, US (if indicated), and management plan.
❒ Preconception
❒ Diabetes, Pre-gestational; Type _____
❒ GDM **Please fax GTT results**
❒ Hypertension; Chronic or Gestational (please circle one)
❒ Isoimmunization
❒ Multiple Gestation, # of fetuses _____
❒ Thyroid dysfunction
❒ Hx of IUFD or Stillbirth
❒ Recurrent pregnancy loss
❒ Anticardiolipin antibody/LAC positive
❒ Seizure disorder
❒ Obesity, BMI: _____
❒ Maternal medical complication: _____
❒ Other: _____

PLEASE FAX ALL ULTRASOUND REPORTS, PRENATAL LABS, MATERNAL SCREENING, AND COPY OF INSURANCE CARD WITH THIS REQUEST