Obstetrix Maternal-Fetal Medicine
Specialists of Houston

Formerly known as Houston Center for Maternal-Fetal Medicine

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Please fax your referral to 832-209-2733 or referral_OBXMFM@mednax.com

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PATIENT INFORMATION

Patient:____________________ DOB:__________ SSN: __________

Address:____________________ City:__________ ZIP: __________

Phone:__________ Alt Phone:__________ Email: __________

INSURANCE INFORMATION

Insurance:____________________ ID #:__________ Group #: __________

Policy Holder:____________________ DOB:__________ Relationship to Pt.: __________

Referring Provider:____________________ NPI# __________

Phone:____________________ FAX:__________ Contact: __________

REQUIRED INFORMATION

Level of Participation:

❒ One time visit for consultation & management plan
❒ Consultation with subsequent outpatient visits (co-management)
❒ Transfer of care

PATIENT SPECIAL NEEDS:

❒ Ambulation constraint
❒ Hearing impaired
❒ Physical/mental challenges
❒ VAD (cardiac assisted device)
❒ None
Other:__________

Number of Fetuses: ________ LMP:________ EDD:______ G:________ P:________ Blood type:________ Antibody screen: __________

Does your patient require an interpreter? ❒ YES ❒ NO If YES, language spoken: __________

❒ **1st 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: __________

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: __________

2nd/3rd TRIMESTER ULTRASOUND: Consultation and management plan provided, if indicated by US findings

❒ Anatomy Scan, Screen for malformations (18-20 weeks)
❒ 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: __________

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: __________

FETAL ECHO:

❒ Known/Suspected fetal arrhythmia ❒ Family history of cardiac condition
❒ IVF ❒ Other: __________

Please fax all ultrasound reports, prenatal labs, maternal screening, and copy of insurance card with this request.