OBSTETRIX MEDICAL GROUP

MATERNAL-FETAL MEDICINE REFERRAL

OBSTETRIX MEDICAL GROUP AT ISSAQUAH

751 NE BLAKELY, SUITE 2030 ● ISSAQUAH, WA 98029 ● PHONE 425-394-5021 ● FAX 425-391-1883

ALONG WITH REFERRAL FORM, PLEASE FAX RECORDS TO 425-391-1883, INCLUDING:

- **Current prenatals**
- **All labs**
- **Previous pregnancy records**
- **All ultrasound reports**
- **Patient's insurance card (both sides)**
- **Any subspecialist records**

NOTE: PLEASE BE CERTAIN THAT A PATIENT IDENTIFIER IS ON EVERY PAGE OF RECORDS SENT TO OUR OFFICE

PATIENT INFORMATION - PLEASE PRINT -

Patient Name:		**DOB:**
Patient Address:		**City / State Zip**
home phone:	**work phone:**	**cell phone:**
LMP ______________________	EDD ______________________	***Interpreter required? ____YES; language:***
EDD by ultrasound	Check here if Not Pregnant _____	

REFERRING PROVIDER INFORMATION

Referring Provider Name: ____ PHONE ____________________

Practice Name:

Address: FAX ____________________

City / State / Zip

REASON FOR REFERRAL:

◯ AMA ◯ Multiple gestation (circle) 2 3 4 5 ◯ GDM ◯ Type 1 or 2 Diabetes

◯ Positive prenatal screen ◯ Other maternal indication____

◯ Other fetal indication____

COMPLETE MFM SERVICES

____ **COMPLETE PERINATOLOGY EVALUATION**
May include MD consult, ultrasound(s), and procedures, as indicated

____ **COMPLETE PRENATAL DIAGNOSIS**
May include genetic counseling, CVS, amnio, NT, ultrasound(s), serum screening, MD consult, as indicated

____ **DIABETES PROGRAM / MANAGEMENT**
Includes management by MD or ARNP, diabetes education & nutrition by certified educators and RN's

____ **MULTIPLES PROGRAM**
May include multiples consult, MD consult, NT, ultrasound(s), NST(s), as indicated (check below):

◯ Dichorionic - Diamniotic
◯ Dichorionic - Monoamniotic
◯ Monoamniotic
◯ Triplets

Referral Form (Issaquah) 7/11

INDIVIDUAL SERVICES ONLY

____ **CONSULTS**
◯ MD Consult
◯ GDM Consult (Nurse specialist)
◯ Dietician Consult
◯ Multiples Consult
◯ Genetic Counseling

____ **TESTS / PROCEDURES**
◯ CVS (includes genetic counseling; full scan required if initial MFM exam)
◯ Amniocentesis (includes genetic counseling)
◯ Fetal lung maturity amniocentesis
◯ NST / AFI
◯ Other________________________________

____ **ULTRASOUNDS**
◯ 1st Trimester US with NT / combined screen
◯ Sequential screen
◯ Detailed US (20 weeks)
◯ Detailed US at ________ weeks
◯ Fetal echo*
◯ BPP*
◯ Gyn, indication: ________________

*** Full scan required if initial MFM exam**