Mary Washington
Maternal Fetal Medicine

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Referral form

Patient Name: _____ Date of Birth: _____/ _____ / _____

Referring physician: _____ Date: _____

Phone: _____ Insurance carrier: _____

Estimated delivery date: _____ Interpreter needed? – specify language:_____

Clinical indication:

_____

_____

_____

Services requested:

- ❑ Diagnostic testing (ultrasound, non-stress test) with consultation, if indicated
- ❑ Consultation (diabetes, preconception, HELLP) with diagnostic testing, if indicated _____
- ❑ Co-management with diagnostic testing
- ❑ Genetic counseling with MFM consultation/diagnostic testing as needed

Checklist of required documents:

- ❑ Demographics/facesheet
- ❑ Copy of insurance card (front and back)
- ❑ Prenatal records (including labs)
- ❑ Genetic testing/carrier screening results
- ❑ **Dating** ultrasounds as well as subsequent ultrasounds
- ❑ Authorization # for patients requiring authorization _____
  (e.g.-Tricare, Blue Choice HMO, Aetna Better Health, United Health-Community Plan)

Preferred appointment date time: _____

Ordering physician signature: _____

Appointment scheduled: _____