Texas Children's Hospital | Pavilion for Women

REQUEST TO ESTABLISH CARE

Baylor College of Medicine — Department of Obstetrics & Gynecology

Today's Date:

A. LOCATION: Please select location.

☐ **Baylor OB/GYN**
Texas Children's Pavilion for Women
6651 Main Street, Suite F320
Houston, TX 77030

☐ **Pearland OB/GYN**
9003 Broadway St.
Pearland, TX 77584

Phone number: 832-826-7500
Fax number: 832-825-9401
Email: BCMViabTOC@texaschildrens.org

Appointment type: ☐ Viability ☐ Transfer of Care

B. PATIENT AND REFERRING INFORMATION: *ALL FIELDS ARE REQUIRED*

Patient name: **Patient DOB:**

Address: **City:** **State:** **Zip:** **Email:**

Home number: **Cell number:** **Work number :**

Is an interpreter needed? □Yes □ No **Language?**

Have you seen a medical professional for this pregnancy? ☐ Yes ☐ No **Name:** **Office Number:**

Reason for transfer request:

Insurance Information: Please include a copy of the insurance card

Primary Insured: □Self □Other **DOB:**

Name of Insurance: **Global Authorization:**

Group#: **ID#:**

C. HEALTH HISTORY

Was this pregnancy assisted? (IVF, fertility drugs, etc.) ☐ Yes ☐ No If yes, please specify

Specify the number of:
Pregnancies including this one:_____ Births (over 37 weeks): _____

Multiple births Type (twins, triplets, etc.)

Premature Births (under 37 weeks) _____ at how many weeks? _____
Delivery Date: _____ Reason: _____

Abortions _____ Miscarriages _____ C-Sections _____
Ectopic pregnancies _____ Living children_____

Height Weight BMI____ _____

Have you had any labs / ultrasounds with this pregnancy? ☐Yes ☐No
Did the ultrasound confirm your due date? ☐Yes ☐No
Estimated due date? _____ Last menstrual period? _____

Have you ever been treated for a high-risk condition such as gestational diabetes, high blood pressure, or another high-risk condition?
☐ Yes ☐ No If Yes, please specify condition:

Do you have any personal health problems? ☐ Yes ☐ No If yes, please describe:

Are you on any medications? ☐ Yes ☐ No If yes, medication name:

Have you had any alcohol or drug use during this pregnancy? ☐Yes ☐No

Goal of Care:

D. SELECT PREFERRED PHYSICIAN:

Please select your preferred provider. If your preferred provider is not available, you will be assigned to another provider.

- □ Nishath Athar Ali, MD
- □ Jennifer M. Bump, MD
- □ Diana K. Crabtree, MD
- □ Matthew R. Carroll, MD **
- □ Allison M. Conn, MD **
- □ Beth Davis, MD **
- □ Tara Harris, MD
- □ Kelly R. Hodges, MD
- □ Richard Todd Ivey, MD
- □ Brennan C. Lang, MD**
- □ Susan Margaret Leong-Kee, MD
- □ Susan Patricia Raine, MD
- □ Audra E. Timmins, MD
- □ Mark Turrentine, MD

***Provider at both locations (PFW and Pearland)*

REQUIRED DOCUMENTATION: Please fax copies of the below documents via fax or email.

□ Completed request form □ Copy of insurance card □ Any current obstetrical records (labs, ultrasounds, etc.)