Fetal Center Referral Form

Date

Referring physician name (OB/GYN and/or subspecialist) | Office phone | Office fax

Practice contact/referral coordinator | Office phone | Office fax

Patient name | E-mail address

Patient address

Patient phone | Alternate phone

Translator needed? If yes, what language? | Patient date of birth

Primary insurance carrier | Phone | Policy number | Group number | Subscriber

Secondary insurance carrier | Phone | Policy number | Group number | Subscriber

Diagnosis/Indication for referral | Gestational age | LMP | EDD

Services requested (please check all that apply):

☐ Comprehensive fetal evaluation as deemed necessary by Texas Children's Fetal Center

☐ Consultation with specific Texas Children's Specialty:

- ☐ Craniofacial/Plastics
- ☐ Fetal intervention/Surgery
- ☐ Genetics
- ☐ Maternal Fetal Medicine
- ☐ Nephrology
- ☐ Neurology
- ☐ Neurosonology
- ☐ Neurosurgery
- ☐ Orthopedics
- ☐ Pediatric Surgery
- ☐ Urology
- ☐ Other: _____

☐ Fetal MRI ☐ Fetal ultrasound ☐ Fetal Echocardiolgram w/ Fetal Cardiology Consult ☐ Transfer of care (pending approval)

Consultation and imaging reports will be transmitted back to your office as fast as possible. In addition to these written materials, would you also like to receive a phone call from the consulting physician? ☐ yes, phone number _____

Is there an additional care provider (i.e. primary OB/GYN) that you would like us to include in post-consult communication?

☐ yes, name _____ phone _____ fax _____

Please fax this form along with all patient medical records including labs, ultrasounds and demographic info to 832-824-7333.

Texas Children's Fetal Center

1-877-FetalRx (338-2579) – Toll-free

832-822-BABY (2229)

Fax: 832-824-7333

Texas Children's Hospital® | Pavilion for Women

texaschildrens.org/fetal