Referral to Maternal Fetal Medicine

Texas Children's Hospital®
Pavilion for Women

Austin Locations

By referring to Maternal Fetal Medicine, you will allow us to provide a clinically appropriate evaluation as deemed necessary by our team. Clinically indicated follow-up will be provided unless otherwise requested by your office.

Date of referral: _____

Fax referral to 512-206-0212
along with patient medical records including labs, previous ultrasound reports, a copy of patient's ID and front/back of insurance card

Check here for ASAP referral ☐

*Patient Information

***Patient Name** | ***DOB** | ***Phone #**

***Address / City / State / ZIP**

***Interpreter Needed?**
- ○ No
- ○ Yes -> Specify Language: _____

***Insurance** (please include copy of insurance card front and back)

Name of Insurance: _____

***Pregnancy Status**
- ○ Not Pregnant
- ○ Singleton
- ○ Twins
- ○ Triplets
- ○ +: _____

***EDD**
_____

***Dating based on:**
- ○ U/S
- ○ LMP

G: _____

P: _____

Primary Insured ○ Self ○ Other -> Name: _____ DOB: _____

*Referring Provider Information

*Provider Name | *NPI | *Office Fax #

*Office Contact Name | *Office Contact Phone #

*Please select ONE, preferred location for your patient's care (form will be updated with additional locations as new sites are implemented)

- ○ Austin Perinatal Associates (Dr. David Berry)

*Requested Services (please select all that apply, must select at least 1)

- ○ MFM Preconception Consult
- ○ Genetic Counseling
- ○ MFM Consult
- ○ First Trimester Screen
- ○ Ultrasound
  - ○ Initial Ultrasound
  - ○ Multiple Gestation
  - ○ Suboptimal Imaging
  - ○ Uterine Anomaly
  - ○ Other: _____
- ○ Amniocentesis (send prenatal labs)
- ○ CVS
- ○ Anatomy
- ○ Cervical Length or Limited US
- ○ Growth
- ○ Antenatal Testing
- ○ Other
  Please explain: _____
- ○ Fetal ECHO
- ○ fFN
- ○ Cerclage Placement
- ○ Cerclage Removal
- ○ Diabetic Education and Monitoring
- ○ Diabetic Education, only (does not include blood sugar monitoring)
- ○ Venipuncture
  - ○ Cell-free DAN/Carrier Screening
  - ○ Other: _____
- ○ Injection/Infusion (pregnancy, only)
  - ○ IV Hydration
  - ○ IV Antiemetics
  - ○ Iron (IV/IM)
  - ○ Steroids (IV/IM)
  - ○ B12
  - ○ Other: _____

*Indications / Diagnosis (must select at least 1)

- ○ Multiple Gestation
  - ○ Twins
  - ○ Triplets
  - ○ Quads
  - ○ 5+
- ○ Routine Ultrasound
- ○ Size-Date Discrepancy
- ○ Suboptimal Imaging
- ○ Positive Screen (include copy of lab)
- ○ AMA
- ○ Diabetes
  - ○ Type I
  - ○ Type II
  - ○ Gestational
- ○ Family History of _____
- ○ Hypertension
- ○ REI / IVF
- ○ Other Medical History
  Please explain: _____
- ○ Other
  Please explain: _____