CookChildren's.

Fetal Center referral form

Patient name: ______________________ DOB: ______________ MRN: ______________

EDD: ______________________ G: ______________ P: ______________

Address: ____

Contact number(s): Cell: ______________ Home: ______________ Work: ______________

Language: ______________________ Email: ______________________

Primary insurance (HMO/PPO/POS): ______________________________

Diagnosis ICD-code: ______________________ Other: ______________________

Indication for referral: ____

Check all requested services. Video consults will be scheduled when appropriate.

Maternal

- ○ **ACHD consult**
- ○ **Genetics consult (including family planning)**
- ○ **MFM consult**
- ○ **MFM transfer of total OB care/assume care**
- ○ **Social Worker/Ronald McDonald House**

Other ______________________

Fetal

- ○ **Fetal ECHO/Pedi Cardiology consult**
  Auth # ______________________
- ○ **Fetal MRI- Auth #** ______________________
- ○ **Pedi Craniofacial consult**
- ○ **Pedi Endocrinology consult**
- ○ **Pedi ENT consult**
- ○ **Pedi Genetics consult**
- ○ **Pedi Hematology/Oncology consult**
- ○ **Pedi Nephrology consult**
- ○ **Pedi Neurology consult**
- ○ **Pedi Neurosurgery consult**
- ○ **Pedi Orthopedics consult**
- ○ **Pedi Pulmonology consult**
- ○ **Pedi Surgery consult**
- ○ **Pedi Urology consult**
- ○ **WeeCare (NICU consult/ Neonatal Palliative Care consult)**
- ○ **Other** ______________________

Appointment priority: ○ ASAP ○ 2-4 Weeks ○ Beyond 4 weeks

Comments: ____

Referring physician: ______________________ Phone: ______________ Fax: ______________

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Physician signature Date/time

Please fax this form, patient pertinent medical records and a copy of the patient's insurance card to 682-885-3223. If you have any questions, regarding the form please contact:

Please attach or reference any additional imaging and/or results done for this patient.

Cook Children's Fetal Center

Website: cookchildrensfetalcenter.org
Email: fetalcoordinator@cookchildrens.org
Phone: 682-885-2158