PERINATAL CENTER *of* IOWA
330 Laurel St., Ste. 2300 • Des Moines, Iowa 50314 • (515) 643-6888 • (877) 415-7447 • Fax: (515) 643-6899

PATIENT REFERRAL FOR SERVICES FORM

Patient Name:	**Maiden Name:**
DOB:	**Emergency contact #:**
Patient Address:	**Referring Provider:**
Patient Phone:	**Office Contact Person:**
Patient's Primary Language:	**Office phone:**
Insurance Plan Name:	**Office Fax:**
Insurance ID:	

----FOR COMPLETION BY CLINICAL STAFF---

Indication for Referral (Diagnosis)_____
(Please fax copies of prenatal records; subspecialty notes; ***laboratory copies*** of maternal blood type and serum screening; all prior ultrasound results to 515-643-6899.)

Obstetric Ultrasound
LMP: _____ EDC: _____ EDC based on LMP/Ultrasound _____
Number of Fetuses _____

- ☐ Viability/Dating < 14 weeks
- ☐ First Trimester Screening/Nuchal Translucency (11-13.6 weeks)
- ☐ Standard (gestational age assignment/anatomic survey) (18-20 weeks)
- ☐ Level II specialized ultrasound & MFM consult (see below)- including but not limited to: known or suspected abnormality or increased risk; AMA; Obesity; HTN; pregestational diabetes; drug exposure; twins
- ☐ Growth/Repeat ultrasound - reevaluation of fetal size and/or reevaluation of specific organ(s) known or suspected to be abnormal
- ☐ Cervical length
- ☐ Limited - amniotic fluid volume; placental location

Diagnostic Testing Patient blood type _____

- ☐ Amniocentesis

Genetic Counseling

- ☐ Preconception (family history, prior child with abnormality, maternal age, etc)
- ☐ Current pregnancy (review risk-appropriate screening options, discuss abnormal result, family history, etc)
- ☐ Other _____

Maternal Fetal Medicine

- ☐ MFM pre-pregnancy consultation
- ☐ MFM obstetric consultation (one time visit with no expectation for follow up)
- ☐ MFM obstetric co-management (follow up at PCI as determined by MFM)
- ☐ Transfer of care to MFM (complete management/delivery by PCI)

Physician Signature:	**Date:**