MFC Maternal Fetal CONSULTANTS

Patient Name: _____

DOB: _____/_____/_____ (mm/dd/yyyy)

Phone #: (_____) _____—_____

Interpreter needed: Y / N Language: _____

INDICATION / REASON FOR REFERRAL: _____

EDD: _____ **LMP:** _____ **Patient BMI:** _____

Please Circle: SINGLE TWIN TRIPLET QUAD

CONSULTATION

Reason for consult request: _____

☐ Maternal Fetal Medicine Consult ☐ Genetic Counseling Consult

ULTRASOUND

☐ First Trimester Ultrasound (less than 14 weeks gestation)

☐ Transvaginal Ultrasound for cervical length assessment

☐ Detailed (Comprehensive) Ultrasound (18+ weeks gestation)

☐ Other specific request _____

FETAL ECHOCARDIOGRAM *Often scheduled after completion of Detailed Ultrasound

☐ Fetal Echocardiogram

☐ Maternal Indication: _____ ☐ Fetal Indication: _____

FETAL SURVEILLANCE

Reason for Fetal Surveillance: _____

☐ Biophysical Profile without NST

☐ Biophysical Profile with NST

☐ Non-Stress Test (NST)

*Patient may proceed with recommendations for further testing as directed by MFM Physician

Prenatal Provider Signature	Date: _____
Prenatal Provider Name (print)	
Referring Clinic	
Clinic Contact	Name: _____ Phone #: (_____) _____—_____ Fax #: (_____) _____—_____

Please send patient's demographic and insurance information, along with any applicable records (prenatal records, prenatal labs, consultation notes, ultrasound reports).

Maternal Fetal Consultants
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