Fetal Center Referral Order

For any questions, please contact our office at (614) 722-BABY (2229) or (833) 762-2229 (BABY).

Date: _____

Indication for Referral: _____

Patient: _____
Maiden Name: _____
DOB: _____
Address: _____
_____
Contact info: _____

Gravida (# of pregnancies): _____
Para (# of births): _____ EDD: _____
LMP: _____ Date: _____
How EDD Established?: ❑ LMP ❑ U/S ❑ Other _____
Gestational Age: _____
❑ Single ❑ Twins ❑ Triplets ❑ Other _____
Genetic Results:_____

Interpreter needed? Yes No If yes, what language is needed? _____

Referring/Attending Physician:

Name	
Office Address	
Phone	Fax

Primary OB: (if different from referring physician)

Name	
Office Address	
Phone	Fax

❑ Check box if referral is for Fetal Echo/Cardiology only

• Urgency _____ • Ht/Wt _____

*Referring office is responsible for obtaining Prior Authorization for the Fetal Echo

Please fax completed form along with the following documents to (614) 355-4445.

- Patient Insurance
- Patient Demographics
- Current Pregnancy Related Medical Records
- Prenatal Serologies
- Genetic Counselor
- Ultrasound reports

Referring/Attending Physician Signature: _____

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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 _____ Text ok? Yes No

(Patient data will **not** be sent via text. Text will only be used to coordinate a telephone call)

Contact number for critical results or unexpected findings: _____

Is there an additional care provider (i.e. PCP, Practice Partner) that you would like us to include in post-consult communications? ❑ No ❑ Yes, Name _____ Phone _____ Fax _____

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When your child needs a hospital, everything matters.