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: _____ Gravida (# of pregnancies): _____

Maiden Name: _____ Para (# of births): _____ EDD: _____

DOB: _____ LMP: _____ Date: _____

Address: _____ How EDD Established?: ❑ LMP ❑ U/S ❑ Other _____

_____ Gestational Age: _____

Contact info: _____ ❑ 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

Referring patient for:

❑ Comprehensive Fetal Center Evaluation

❑ Specific Services Requested (please check all that apply):

❑ Cardiology/Fetal Echo*
Urgency _____
Ht/Wt _____
❑ Cardiovascular Surgery
❑ Fetal MRI/Sonography**
❑ Genetics
❑ Maternal-Fetal Medicine
❑ Neonatology
❑ Nephrology
❑ Neurology
❑ Neurosurgey
❑ Orthopedic Surgery
❑ Palliative Care
❑ Plastic and/or Craniofacial Surgery
❑ Pediatric Surgery
❑ Urology
❑ Other _____
❑ Other _____

*Referring office is responsible for obtaining Prior Authorization for the Fetal Echo
**NCH will place orders and complete prior authorizations for Fetal MRI and Ultrasounds

❑ Fetal Echo Scheduled: _____

By referring for a Comprehensive Fetal Center Evaluation, you will allow NCH to evaluate and provide services as deemed necessary by The Fetal Center.

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 _____

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

❑ Patient Insurance
❑ Patient Demographics
❑ Patient Medical Records
❑ Prenatal Serologies
❑ Genetic Counselor
❑ Ultrasound reports

Referring/Attending Physician Signature: _____

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