## Fetal Center Referral Order

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

Date: ____________________ Indication for Referral: ________________________________________

Patient: ________________________________ Gravida (# of pregnancies): ________________

DOB: _________________________________ Para (# of births): ______________________

Address: _______________________________ EDD: ____________ LMP: ____________

_______________________________________ Gestational Age: _______________________

Contact info: ____________________________ ❑ Single ❑ Twins ❑ Triplets ❑ Other ________

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

**Referring Physician:**

| Name | |
|---|---|
| Office Address | |
| Phone | Fax |

**Primary OB:** (if different from referring physician)

| Name | |
|---|---|
| Office Address | |
| Phone | Fax |

**Insurance Information:** ❑ check if insurance card included in fax; following sections do not need completed

| Insurance Carrier: | Policy #: | Group #: | Subscriber: |
|---|---|---|---|
| Claims Address: | | Insurance Carrier Phone #: | |

Referring patient for:

❑ Comprehensive Fetal Center Evaluation

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

- ❑ Cardiology/Fetal Echo
- ❑ 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 ____________

*NCH will place orders and complete prior authorizations for Fetal MRI and Ultrasounds

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 medical records
- ❑ Prenatal serologies and other tests
- ❑ Genetic counselor notes and any genetic testing results
- ❑ Ultrasound reports
- ❑ Patient demographics (including copy front and back of insurance card)

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