UFHealth
UNIVERSITY OF FLORIDA HEALTH

UF Health Women's Center
Maternal Fetal Medicine
PO Box 100354, Gainesville, FL 32610-0354

Maternal Fetal Medicine Referral

Complete the **ENTIRE** form and include the following:

Current Prenatal Records | **Lab Reports** (Prenatal, Blood type) | **Dating & OB Ultrasound Reports** | **Genetic Screening/Tests**

Missing records may delay scheduling.

Date: ____________ Patient Name: ____ DOB: _____________________

Address: ____

Phone Number: _______________________ Alternate: _______________________ Language: _________________________

Pregnant: ☐ Y / ☐ N EDD: ___________ LMP: ___________ Dating US on: _______________ Pre-Pregnancy BMI: ________

INDICATION(S) FOR REFERRAL/DIAGNOSIS: ____

____

SELECT YOUR SERVICE OPTION(S):

- ☐ MFM Consultation (Ultrasound as needed)
- ☐ Ultrasound: select below (MFM Consult as needed)
- ☐ Transfer of Care/Delivery at Shands
- ☐ Genetic Counseling
- ☐ Preconception Consultation

SELECT YOUR ULTRASOUND/PROCEDURE OPTION(S):

- ☐ Early Pregnancy/AB<12wks (76801)
- ☐ 1ST Trimester/NT 12w-13w6d (76813)
- ☐ Routine ("Low-risk") Anatomy (76805)
- ☐ Detailed ("Level II") Anatomy (76811)
- ☐ Fetal Growth (76816)
- ☐ NST/Biophysical Profile (76818)
- ☐ CVS/Amniocentesis (59015/76945/59000/76946)
- ☐ Other: ____

Referring Provider/Practice: ___________________ Contact person completing this form: ______________________________

Address: ____

Phone: __________________________ Fax (Route Results/Recommendations to): ______________________________

Is there a primary OB provider that you would like us to include in post consult communication?

☐ Yes – Name/Phone/Fax: ____

Primary Insurance: ____ Policy #: ________________ Group #: ________________

Secondary Insurance: _____________________________________ Policy #: ________________ Group #: ________________

Pre-Authorization #: ____

☐ **Next Available** ☐ **Urgent** ☐ **Other:** ____

Fax to: 352.627.4902