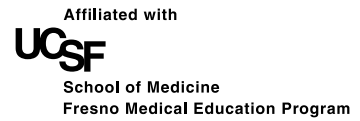


FAX REFERRAL REQUEST

- Brian Morgan, M.D., Ph.D.
Subhashini Ladella, M.D.

University Women's Specialty Center

2210 E. Illinois Avenue, Suite 301 · Fresno, CA 93701
Phone: 559.320.0555 · Fax: 559.256.4468
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Referrals can be made by faxing this form or calling the office.

Date: Number of Pages:
Name: DOB:
Cell Number: Home or Work Number
Insurance Company Name:

Insurances may require pre-authorization

Name of Insured: Policy Number:
Pregnancy Dating: LMP: EDD (Please note method)
EDD by LMP: or EDD by Ultrasound
Date of US: Fetal Size: Multiple Gestation? If yes, # of fetuses:

Services Requested: Diagnostic Studies Consultation Co-Manage Assume Care

First Trimester: Nuchal Translucency, Ultrasound Dating, Ultrasound Viability
Second Trimester: Abnormal AFP, Detailed Fetal Survey/Screening Exam, Fetal Echocardiogram, Genetic Counseling, Rule out Fetal Demise
Third Trimester: Amniocentesis for Fetal Lung Maturity, Anatomy Assessment, Fetal Growth
Other Services: Evaluate for Cervical Cerclage, Genetic Counseling, Non-Stress Test (NST), Preconception Consultation, Preterm Labor, US Exam or other Fetal Testing as determined by Perinatologist

Reason for Referral:

REQUIRED

Indication based on ICD-10 (Please check boxes below):

Routine Codes for First Trimester Screening, Prenatal Diagnosis, Maternal Medical Condition, Pregnancy and/or Placental Complications

Signature of Ordering/Referring Physician:

Printed Name: Date:

Referring Contact: Phone: Fax:

INTERNAL USE ONLY

Appointment Date: Time: Medical Record #: