FAX REFERRAL REQUEST

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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 (11 – 14 weeks)
- ☐ Ultrasound Dating (6- 12 weeks)
- ☐ Ultrasound Viability (6- 12 weeks)

Second Trimester:
- ☐ Abnormal AFP
- ☐ Detailed Fetal Survey/Screening Exam (16-23 weeks)
- ☐ Fetal Echocardiogram
- ☐ Genetic Counseling, Ultrasound and/or AMNIO
- ☐ 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
- ☐ Z36 Nuchal Translucency (11 – 14 weeks)

Screening for Fetal Abnormality
- ☐ O35.8XX0 Known or Suspected Fetal Abnormality
- ☐ O35.1XX0 Suspected Chromosomal Abnormality
- ☐ O35.5XX0 Suspected Damage of Fetus From Drugs/Meds

Prenatal Diagnosis
- ☐ O09.519 Advanced Maternal Age Primagravida (AMA)
- ☐ O09.529 Advanced Maternal Age Multigravida (AMA)

Maternal Medical Condition
- ☐ O99.019 Anemia, Complicating Pregnancy
- ☐ O26.619 Cholestasis
- ☐ O10.09 Essential Hypertension
- ☐ O24.919 Diabetes Mellitus
- ☐ O24.419 Gestational Diabetes
- ☐ O99.350 Seizure Disorder
- ☐ O99.280 Thyroid Dysfunction

Pregnancy and/or Placental Complications
- ☐ O36.5990 Size/Dates, Fetal Growth Poor
- ☐ O36.60X0 Size/ Dates, Fetal Growth Excessive
- ☐ O41.00X0 Oligohydramnios
- ☐ O44.00 Placenta Previa w/o Bleeding
- ☐ O40.9XX0 Polyhydramnios
- ☐ O48.0 Post Term
- ☐ O26.859 Spotting/Vaginal Bleeding w/ Pregnancy
- ☐ O47.9 Threatened Premature Labor
- ☐ O30.009 Twin Pregnancy

Signature of Ordering/Referring Physician: _____

Printed Name: _____ Date: _____

Referring Contact: _____ Phone: _____ Fax: _____

* INTERNAL USE ONLY *

Appointment Date: _____ Time: _____ Medical Record #: _____