Maternal Fetal Medicine

Parker Perinatal Center Referral Form

p: 303-315-6100, option 2 | f: 303-840-4713

Referring Provider:____

Phone #______________________________ Fax #______________________________

Physician Signature ____

PATIENT INFORMATION:

Name______________________________ DOB ______________ Age ________

Please attach facesheet / demographics

Phone #1______________________________ Phone #2 ______________________________

INSURANCE INFORMATION (please fill in completely):

Company Name ____

I.D. #______________________________ Group # ______________________________

If required, prior authorization is the responsibility of the referring provider. Thank you!

MATERNAL HISTORY

LMP:____________________ EDC ____________________ (by US or LMP) IUI or IVF ____________________

G ______ P ______ Term ______ Preterm ______ SAB ______ TAB ______ Ectopic ______ Stillbirth ______ Living Children ______

Allergies ______________________________ Blood Type________Rh ________Antibody Screen__________

SERVICES REQUESTED (please check all that apply):

____Preconceptual consultation regarding:

____Early detection screening for risk of Down syndrome, Sequential or cfDNA

____High risk ultrasound in the 2nd trimester *Please fax Genetic Screening results

____Doppler Evaluation

____Echocardiogram (screening only)

____Chorionic Villus Sampling (CVS) *Please fax patient blood type and Rh factor

____Amniocentesis *Please fax patient blood type and Rh factor

____Multiple Gestation

____Cervical Length

____ Gestational Diabetes

Indication for Request of Service: (Please include all indications and patient records)

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Other Offices:

❑ Littleton - Littleton Perinatal Center
p: 303-315-6100, option 3 f: 303-468-3481

❑ Lone Tree - Lone Tree Health Center
p: 720-848-2200 f: 720-553-0901