Colorado Institute for maternal & fetal Health

Maternal Fetal Medicine

Platte River Perinatal Center Referral Form

p: 303-315-6100, option 1 | f: 303-468-3481

Referring Provider: _____

Phone # _____ Fax # _____

Physician Signature _____

PATIENT INFORMATION:

Name _____ DOB _____ Age _____

Address _____

_____

Phone #1 _____ Phone #2 _____

INSURANCE INFORMATION (please fill in completely):

Company Name _____ Primary Insured _____ DOB _____

I.D. # _____ Group # _____

Insurance Company Phone # _____

Authorization # _____ Per: _____ By: _____ Date: _____

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 _____

SERVICES REQUESTED (please check all that apply):

____Perinatal consultation regarding: _____

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

____High risk ultrasound in the 2nd trimester *Please fax Quad Screen 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

____Twins

____Cervical Length

____ Gestational Diabetes

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

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