Dartmouth-Hitchcock

PROVIDER REQUISITION & REFERRAL FORM
Maternal-Fetal Medicine & Prenatal Diagnosis Program
Radiology Department

Patient Name _____ Patient DOB _____

Maiden Name _____ Patient SSN _____

Address _____ Insurance _____

_____ PCP _____

Home Phone _____ Marital Status _____

Work Phone _____ Partner's Name _____

Cell Phone _____ Partner's DOB _____

Provider Name _____ Date of Referral _____

Office Address _____ Form Completed By _____

_____ Office Phone _____

_____ Office Fax _____

Appointment Request Information:

Currently Pregnant? ❑ Yes ❑ No Gravida _____ Para _____ SAB _____ EAB _____ Living _____ Stillborn _____

LMP _____ EDD _____ Date of **first** US _____ Gestational age of US _____

Height _____ Weight _____ Blood Type _____ MCV _____ Is the patient aware of this referral? ❑ Yes ❑ No

Appointment Request Indication(s) – Evaluate and Treat as Appropriate:

- ❑ Maternal Age
- ❑ Screen Positive for Down Syndrome
- ❑ Screen Positive for Trisomy 18
- ❑ Screen Positive for Neural Tube Defect
- ❑ Family History: _____
- ❑ Abnormal Ultrasound Finding: _____
- ❑ Previous Pregnancy Abnormalities: _____
- ❑ Maternal Condition: _____
- ❑ Multiples ❍ Twins ❍ Triplets ❍ Other: _____ _____
- ❑ Other: _____

Service(s) Requested:

- ❑ Nuchal Translucency Ultrasound (w/ WIH lab requisition)
- ❑ Endovaginal ❍ cervical length ❍ dating/viability ≤ 14 wk
- ❑ Targeted Morphology (Level 2) Ultrasound
- ❑ Growth (EFW/Growth) – Singleton
- ❑ Growth (EFW/Growth) – Multiples
- ❑ Biophysical Profile
- ❑ Doppler Studies ❍ MCA ❍ UA
- ❑ Genetic Counseling
- ❑ Maternal-Fetal Medicine Consultation
- ❑ Transfer of Obstetric Care
- ❑ Fetal Echocardiogram
- ❑ Amniocentesis (w/ ultrasound guidance)
- ❑ Other: _____

Location preference:

❑ **Lebanon**
One Medical Center Drive
Lebanon, NH 03756
Phone: 603-653-6025
Fax: 603-653-9363

❑ **Bedford**
5 Washington Place
Bedford, NH 03104
Phone: 603-695-2902
Fax: 603-623-7216

❑ **Nashua**
2300 Southwood Drive
Nashua, NH 03060
Phone: 603-577-4077
Fax: 603-577-3497