

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 _____
Provider Signature _____	Form Completed By _____
Office Address _____	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:

- | | |
|--|--|
| <input type="checkbox"/> Maternal Age (<input type="checkbox"/> 009.519 1 st preg <input type="checkbox"/> 009529) | <input type="checkbox"/> Abnormal Ultrasound Finding (028.3): _____ |
| <input type="checkbox"/> Screen Positive for Down Syndrome (<input type="checkbox"/> 0028.5) | <input type="checkbox"/> Previous Pregnancy Abnormalities (009.291) _____ |
| <input type="checkbox"/> Screen Positive for Trisomy 18 (<input type="checkbox"/> 0028.5) | <input type="checkbox"/> Multiples <input type="radio"/> Twins (030.009) <input type="radio"/> Triplets (030.191) <input type="radio"/> Other: _____ |
| <input type="checkbox"/> Screen Positive for Neural Tube Defect (<input type="checkbox"/> 0028.5) | <input type="checkbox"/> Maternal Condition: _____ |
| <input type="checkbox"/> Family History: _____ | <input type="checkbox"/> Other: _____ |

Required ICD10 _____

Service(s) Requested-Please check desired ultrasound boxes

- | | |
|---|---|
| <input type="checkbox"/> Nuchal Translucency Ultrasound (w/ WIH lab requisition) | <input type="checkbox"/> Genetic Counseling |
| <input type="checkbox"/> Endovaginal <input type="radio"/> cervical length <input type="radio"/> dating/viability ≤ 14 wk | <input type="checkbox"/> Telehealth Genetic Counseling |
| <input type="checkbox"/> Targeted Morphology (Level 2) Ultrasound | <input type="checkbox"/> Maternal-Fetal Medicine Consultation _____ |
| <input type="checkbox"/> Growth (EFW/Growth) - Singleton | <input type="checkbox"/> Transfer of Care |
| <input type="checkbox"/> Growth (EFW/Growth) - Multiples | <input type="checkbox"/> Fetal Echocardiogram |
| <input type="checkbox"/> Biophysical Profile | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Doppler Studies <input type="radio"/> MCA <input type="radio"/> UA | |
| <input type="checkbox"/> Follow up Ultrasound with MFM | |

Location preference:	<input type="checkbox"/> Lebanon One Medical Center Drive Lebanon, NH 03756 Phone: 603-653-9300 opt#5 Fax: 603-653-9363	<input type="checkbox"/> Bedford 5 Washington Place Bedford, NH 03104 Phone: 603-695-2902 Fax: 603-623-7216	<input type="checkbox"/> Nashua 2300 Southwood Drive Nashua, NH 03060 Phone: 603-695-2902 Fax: 603-623-7216
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