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 ____________________
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

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

- ❑ Maternal Age (1st preg ❑O09.519 2nd +❑O09529)
- ❑ Abnormal Ultrasound Finding (O28.3): ____________________
- ❑ Screen Positive for Down Syndrome (❑O028.5)
- ❑ Previous Pregnancy Abnormalities (O09.291) ____________________
- ❑ Screen Positive for Trisomy 18 (❑O028.5)
- ❑ Multiples ❍ Twins (O30.009) ❍ Triplets (O30.191) ❍ Other: _____
- ❑ Screen Positive for Neural Tube Defect (❑O028.5)
- ❑ Maternal Condition: ____________________
- ❑ Family History: ____________________
- ❑ Other: ____________________

Required ICD10 ❑ ____________

Service(s) Requested-Please check desired ultrasound boxes

- ❑ 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
- ❑ Telehealth Genetic Counseling
- ❑ Maternal-Fetal Medicine Consultation
- ❑ Transfer of Care
- ❑ Fetal Echocardiogram
- ❑ Other: ____________________

Location preference:

❑ **Lebanon**
One Medical Center Drive
Lebanon, NH 03756
Phone: 603-653-9300 opt#7
Fax: 603-676-4080

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

❑ **Nashua**
2300 Southwood Drive
Nashua, NH 03060
Phone: 603-695-2902
Fax: 603-623-7216