# Memorial Hermann Health System
# Maternal-Fetal Medicine Services Referral Order

**MH Cypress – MFM**
27800 Northwest Freeway, Cypress, Texas 77433, Main Tower - M1.100 **P:** 346-231-4060 **F:** 346-231-4066

*Please fax your referral to the desired location.*

Date of Referral:_____ ☐ Urgent MFM Referral ☐ MFM to follow for the duration of the pregnancy.

Patient Name: _____ Date of Birth: _____

Cell Phone:_____ Alt. Phone:_____

**CLINICAL INFORMATION**

LMP: _____ EDD: _____ G: ____ P: _____

Does your patient require an interpreter? ☐ YES ☐ NO If YES, preferred language:_____

Additional clinical information/special needs: _____

_____

| **INDICATION FOR REFERRAL**<br>Please check all that apply | **REQUESTED SERVICES**<br>Please check all that apply |
|---|---|
| **Genetic counseling may be provided for these indications, unless declined by patient or referring provider.*<br>☐ Abnormal genetic screening<br>☐ Abnormal maternal labs: _____<br>Please specify:_____<br>☐ Advanced maternal age*<br>☐ Counseling for genetic screening options<br>☐ Hypertension<br>☐ Multiple gestation ☐ Twins ☐ Triplets<br>☐ Obesity<br>☐ Placenta accreta<br>☐ Placental location<br>☐ Positive family history*<br>Please specify: _____<br>☐ Pregestational diabetes or gestational diabetes<br>Please specify: _____<br>☐ Prior preterm birth or Prior stillbirth<br>☐ Size-dates discrepancy<br>☐ Suspected fetal anomaly*<br>Please specify: _____<br>☐ Thyroid disease<br>☐ Ultrasound screen for anomalies<br>☐ Viability<br>☐ Other indication:_____<br>_____ | **Ultrasound**<br>☐ First trimester scan<br>☐ Fetal anatomy ultrasound<br>☐ Fetal echocardiogram screening<br>☐ Follow-up or growth ultrasound<br>☐ Cervical length by transvaginal ultrasound<br>☐ 16-24 wks. transvaginal US to be performed<br>**Antenatal testing**<br>☐ Biophysical profile (weekly, if indicated)<br>☐ Fetal doppler ultrasound (weekly, if indicated)<br>☐ Non-Stress Test (NST)<br>☐ Other: _____<br>**Procedures**<br>☐*Amniocentesis: _____<br>☐*Chronic villus sampling (CVS): _____<br>**Consultation (Please list indication)** Telemedicine preferred<br>☐ Preconception MFM consultation:_____<br>☐ Prenatal MFM consult: _____<br>☐ Co-management with MFM: _____<br>☐ Transfer of care to MFM: _____<br>☐ Preconception genetic counseling: _____<br>☐ Prenatal genetic counseling: _____<br>☐ Diabetes education: _____<br>☐ Other: _____<br>_____ |

**REFERRING PROVIDER INFORMATION**:

Office Number: _____Fax:_____ Preferred Office Contact:_____

☐ I, referring provider, attest that I have discussed this referral with the patient, and the patient has provided consent to the sharing of their demographic and contact information with Memorial Hermann or its affiliated providers for the purposes related to this referral, including: (1) telephone calls and text messages regarding health care, including but not limited to scheduling, reminders, and medication refills; (2) email or mail communications regarding health care, including but not limited to scheduling, reminders, and medication referrals; and (3) other information regarding my health care, billing and health related services and benefits. I have instructed the patient if they wish to revoke this consent, they may contact Memorial Hermann at 713-222-CARE (2273) or opt out directly after receipt of communication.

| _____ | _____ | _____ | _____ | ☐ AM<br>☐ PM | _____ |
|---|---|---|---|---|---|
| **Provider Signature** | **Print Name** | **NPI/MHHS ID.** | **Date** | **Time** | **Contact No.** |

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