Memorial Hermann Health System
Request for Maternal-Fetal Medicine Services: Secondary Referral Order

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

Patient Name: _____ Date of Birth: _____

Date of Referral: _____

CLINICAL INFORMATION

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

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

Additional clinical information/special needs: _____

_____

SERVICES REQUESTED:			**INDICATION FOR REFERRAL**
Date	**Time**	**Service**	[SELECT 1 OR MORE]
			☐ Ultrasound screen for anomalies ☐ Size-dates discrepancy Large for Gestational Age (LGA) Small for Gestational Age (SGA) Intrauterine Growth Restriction (IUGR) ☐ Suspected Fetal Anomaly- specify: _____ ☐ Multiple Gestation: _____ ☐ Reproductive Technology used ☐ Advanced Maternal Age (AMA) ☐ Abnormal FIRST/ abnormal quad or penta / abnormal NIPT ☐ Diabetes Type: Type I / Type II / Gestational ☐ Hypertension (HTN): Chronic HTN / Gestational HTN ☐ Thyroid disease Hyper or Hypo _____ ☐ Obesity BMI: _____ ☐ Placental location ☐ Positive family history-Specify: _____ ☐ Prior preterm birth ☐ Prior stillbirth ☐ Other: _____ _____

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
☐ PM

Provider Signature	**Print Name**	**NPI/MHHS ID.**	**Date**	**Time**	**Contact No.**

MEMORIAL HERMANN

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