Children's MEMORIAL HERMANN

UTHealth The University of Texas Health Science Center at Houston | McGovern Medical School

Fetal Center Referral Order

Please fax this form along with patient medical records, prenatals, labs, ultrasounds and patient demographics, to 713.383.1464.
For any questions please do not hesitate to contact our office at 832.325.7288 or toll free at 1.888.818.4818.

Date:_____

Indication for referral: _____

Gravida (# of pregnancies): _____ Para (# of births): _____

Estimated Date of Delivery (by ultrasound or last menstrual period) ____/___/____ last menstrual period: ____/___/____

Genetic testing results (if applicable): _____

Referring Physician		**Primary OB** *(If different from referring physician)*	
Name:		Name:	
Office Address:		Office Address:	
Phone/Back line:	Fax:	Phone/Back line:	Fax:

Patient Information

Patient Name:			Date Of Birth:
Patient Address:	City:	State:	Zip:
Home Phone:	Cell Phone:	Work Phone:	

Insurance Information

Insurance Carrier:	Policy #:	Group #:	Subscriber:
Claims Address:		Insurance Carrier Phone #:	
Office contact for Referral and Authorization:			

By referring to The Fetal Center you will allow us to evaluate and provide a comprehensive fetal evaluation as deemed necessary by The Fetal Center. Additional laboratory or prenatal diagnostic testing maybe ordered as clinically indicated.

Services requested (please check all that apply):

- ☐ Cardiology/Fetal ECHO
- ☐ Cardiovascular surgery
- ☐ Fetal intervention
- ☐ Fetal MRI
- ☐ Fetal ultrasound
- ☐ Prenatal genetics
- ☐ Maternal-fetal medicine
- ☐ Nephrology
- ☐ Neurology
- ☐ Neurosurgery
- ☐ Pediatric orthopedic surgery
- ☐ Pediatric plastic and craniofacial surgery
- ☐ Pediatric surgery
- ☐ Transfer of obstetrical care
- ☐ Urology
- ☐ Other: _____

Thank you for the privilege of caring for your patient

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