USF Perinatology Intake Form

Patient Name: ____ Date: ______________________________________

Patient Contact Number: ____

Ordering Provider: ____

Office Phone Number: _________________________________ Office Fax Number: ___________________________

Office Contact: ____

*** Please indicate if patient has been notified about referral reason: Yes No**

LMP______ EDC _______ (by LMP ______ or U/S ______ PLEASE FILL IN THE DATE OF U/S) DOB________ G_______ P_______

Referring Diagnosis is required for diagnostic testing. Suspected or rule-out statements are not applicable. If no confirmed diagnosis, please list symptoms. Diagnosis/Indication for Test: ____

<u>Consultation</u> (must be scheduled)

__ MFM ___ Genetic Counseling __Diabetes Management __TOC (Transfer of Care) ___Preconception ___ Exposure/Teratogen Clinic

Please note: **With all consultations, with the exception of preconception an ultrasound may be required. If patient is being seen for diabetes, please have patient bring glucose log to appointment or include a copy of numbers with referral. If patient is being seen for exposure/teratogen counseling please provide a complete list of exposures, including timing and dosage, if applicable. For genetic counseling please send all genetic screening and testing results, if available.**

First Trimester Ultrasound

___Viability/Confirm Dates (less than 14 weeks ___Other ____________________

___Nuchal Translucency & Genetic Counseling **(if no previous dating u/s in your office also order viability above)**

Second & Third Trimester Ultrasound and (Consult if Needed)

__ Detailed Fetal Anatomy (greater than 14 weeks) __ Level II (greater than 14 weeks)

__ Follow-up Anatomy (greater than 14 weeks)

__ Cervical Length/Transvaginal Scan/Limited OB Scan ___ Serial as indicated

__ Growth Scan/Estimated Fetal Weight ___ Serial as indicated

__ Placental Localization/Limited Scan

__ Doppler; Umbilical Artery ___ Serial as indicated

__ Doppler; Middle Cerebral Artery ___ Serial as indicated

__ Non-Stress Test (NST)

__ Biophysical Profile with NST ___ Serial as indicated

__ Biophysical Profile without NST ___ Serial as indicated

__ Fetal Echo Initial and/or Follow-up ___ Serial as indicated

Submission of this referral form authorizes for additional testing, including, but not limited to, BPP/NST, growth scan, or cervical length if deemed indicated at the time of patient's ultrasound. Also MFM and/or genetic counseling are authorized for any abnormal findings.

OB Procedures*

__ Chorionic Villus Sampling (CVS) with ultrasound guidance __ Amniocentesis with ultrasound guidance

Other: ________________________

*Genetic Counseling may be provided for these visits. Blood type, HIV/HepB, and antibody results are required.

Please fax this form completed in its entirety with Medical Records, Prenatal Labs, Demographics, and Copy of Insurance card (s) to(813) 259-0679. Please allow up to 72 hours for appointments to be made. Thank you.

Dr. M Cain, Nevena Krstic, MS, CGC, Dr. C Lockwood, Dr. Jan Lanouette, Dr. J Louis, Dr. Louis-Jacques, Dr. A Odibo, Dr. S Obican, Dr. A Rodriguez, Dr. S Romero, Dr. Jerome Yankowitz

Office Use Only: Medical Record# __________________________ Appointment Date: _____________________________