NORTH MEMORIAL HEALTH

Maternal Fetal Medicine Center
Service Request/Referral Order

***Please circle preferred location*.**
Robbinsdale Maple Grove
Phone: 763-581-5140

Please fax this form with **complete** documentation to **763-581-5141**.
When we receive all of the following information, your patient will be called to set up an appointment.

☐ Prenatal referral form
☐ Prenatal reports and labs with **blood type**
☐ All ultrasound reports from current pregnancy
☐ First trimester screen result or Triple/Quad screen results

Today's date _____ **Clinic contact person** _____

Referring Provider Name _____

****Referring Provider Phone number:*** _____

****Referring Provider Fax number***: _____

**** Referring provider phone and fax are required for a copy of any MFM reports***

Patient name _____ **DOB** _____ **SSN** _____

Best phone number to reach patient _____/_____

Interpreter needed? ☐ Yes ☐ No If yes, language _____

LMP _____ **EDC** _____ by ultrasound? ☐ Yes ☐ No

Indication for Referral/Diagnosis _____

☐ Singleton ☐Twins ☐Triplets ☐ Quadruplets

Providers please check all that apply.

CONSULTATION: Maternal Fetal Medicine specialist (the patient may proceed with recommendations for further testing or genetic counseling as directed by MFM)

☐ one time only ☐ co-management ☐ transfer of complete OB Care (must be approved by MFM MD)
☐ Genetic Counseling (patient may proceed with recommendations for further testing/screening as directed by GC of MFM)
OR
☐ Genetic Counseling only

ULTRASOUND: Patients will receive interpretation and consultation of ultrasound findings.

☐ First trimester screen US with lab and genetic counseling
☐ First trimester complete US (less than 14 weeks gestation) (dating, zygosity, etc.)
☐ Limited US (fetal heart rate, position, placental location, AFI)
☐ Limited including transvaginal (TVS for cervical length assessment)
☐ Comprehensive (level 2) ultrasound (18 weeks gestation & up) (fetal & maternal evaluation includes biometry & anatomy evaluation). AMA patients with no previous screening will be scheduled for genetic counseling.
☐ Fetal echocardiogram
☐ Follow up comprehensive (growth)

PROCEDURE:

☐ Chorionic Villus Sampling (10+0 to 12+6 weeks gestation, genetic counseling will be scheduled)
☐ Genetic Amniocentesis (15+ weeks gestation, genetic counseling will be scheduled)
☐ Lung maturity amniocentesis (if fetal lungs are mature, delivery will be recommended within 36 hours of results – please schedule accordingly)

FETAL SURVEILLANCE:

☐ Biophysical profile w/o NST ☐ 1x only ☐ Weekly ☐ Twice weekly ☐ Per MFM
☐ Biophysical profile with NST ☐ 1x only ☐ Weekly ☐ Twice weekly ☐ Per MFM
☐ Non-stress test (NST) ☐ 1x only ☐ Weekly ☐ Twice weekly ☐ Per MFM

Physician/CNM/NP Signature: _____

(Reminder: a signed order request, provider fax and phone numbers, and prenatal records are required prior to our office calling the patient.)

Our staff are available to discuss your concerns by phone or assist your staff with the referral process.
Please call us at **763-581-5140**