Charlotte Fetal Care Center Referral Form

Patient Name: ____________________________DOB: ____________SS#________________

Home phone: ___________________________ Work phone: ____________________________

Address: ____

City: _______________________ State: ___________ Zip: _____________

Insurance Company: ____

Precertification? Y or N Authorization #: ____

Referring OB__________________________ Referring OB Practice: ____________________

Office Contact: _________________________

Referring OB Phone: ____________________ Referring OB Fax: ________________________

Referring MFM________________________ Referring MFM Practice: __________________

Office Contact: _________________________

Referring MFM Phone: __________________ Referring MFM Fax: ______________________

PREFERRED # FOR UPDATES TO REF PHYSICIAN (cell, pager):

Suspected fetal condition: ____

LMP: _____________________ **EDD:** ____________________ **GA:** __________________

Dating by: LMP or Ultrasound (please circle) Date of first ultrasound: ________________

Blood type & Antibody screen: __________ **(**Documentation required on ALL patients**)**

Interpreter needed? Y or N_____________________________________ **(Language)**

ULTRASOUND

_____Twin-Twin Transfusion Syndrome: Stage (if known): ___________________

____High order multiple gestation (# fetuses_______)

____Complicated multifetal pregnancy

____Other____

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***Please fax all OB and MFM records including labs, u/s reports, demographic page, and copy of insurance card to 704-446-2737. ***

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office use only:

Hx: ____________________ Mailed Packet: _________________________________

Appt date: ___________ Time: ______________ Physician: ______________________

Other appointments scheduled: ____