UHealth Jackson Maternal-Fetal Medicine

UHealth Jackson Center for High Risk Perinatal Care
Consultation and/or Tranfer of Care Form
Phone: 305-585-4636 | Fax: 305-355-2415
Email: MFMreferrals@jhsmiami.org

Patient Name: _____ DOB: _____

Address: _____

Phone: _____

Total Preg: _____ Term: _____ Preterm: _____ SAB: _____ TOP: _____ Ectopic: _____

LMP: _____ EDD: _____ Based on: ☐ LMP ☐ US ☐ Other: _____

Height: _____ Pre-Pregnancy Weight: _____

Allergies: _____ Intrepreter: ☐ Y ☐ N Language: _____

Earliest US: Date: _____/_____/_____ = _____ weeks

Insurance: _____ ID#: _____

Type of Service Requested: ☐ Consultation Only ☐ Co-Management ☐ Transfer of Care

ALL MEDICAL RECORDS MUST BE RECEIVED FOR APPOINTMENT TO BE SCHEDULED INCLUDING:

— Progress Notes — Consultation Reports — Original Lab Results

— Operative Reports — All Prior Ultasound Reports — Discharge Summaries

— Previous Pregnancy Records

INDICATION:

- ☐ Preconception
- ☐ Placental abnormalities
- ☐ Cervical insufficiency
- ☐ Multiple gestations
- ☐ Hypertensive disorders of pregnancy
- ☐ Rheumatic/Connective Tissue Disease (SLE, RA)
- ☐ Chronic renal disease
- ☐ Diabetes
- ☐ Active thyroid disease
- ☐ Current or previous thrombosis, or thrombophilia
- ☐ Hemoglobinopathy
- ☐ Neurologic disorders
- ☐ Cardiac disease
- ☐ Bleeding disorder
- ☐ Alloimmunization
- ☐ Fetal growth disturbance
- ☐ Inborn errors of metabolism
- ☐ Current substance abuse
- ☐ Severe asthma
- ☐ Previous preterm delivery
- ☐ Previous Cesarean x 3 or more
- ☐ Previous Cesarean x 2 requesting TOLAC
- ☐ Malignancy
- ☐ Fetal anomalies
- ☐ BMI > 40 kg/m2 with comorbidities
- ☐ BMI > 50 kg/m2
- ☐ Infectious disease
- ☐ Marfan, Ehlers Danlos, Risk for Aortic Root Disease
- ☐ Portal hypertension
- ☐ GI disease (on medication or with previous GI surgery), History (ex. Crohn's)
- ☐ Uterine anomalies
- ☐ Recurrent pregnancy loss
- ☐ Patient undergoing non-obstetric procedure during pregnancy

For unlisted indications, please call 305-585-4636 option 1 to speak to a provider.

Referring Provider Name (Print): _____ Phone: _____

Address: _____ Fax: _____

Signature: _____ Date: _____

If the patient does not meet high-risk criteria listed above, please schedule an appointment in the JMH ACC Low-Risk Obstetrics Clinic by faxing referral to 305-585-6381. Clinic phone number is 305-585-5467, option 1, then 3.