UHealth Jackson Fetal Care Center
Consultation and/or Transfer of Care Form
Phone: 305-585-4636 | Fax: 305-355-2415
Email: MFMreferrals@jhsmiami.org

UHealth Jackson
Fetal Care Center

REFERRAL FORM

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

PATIENT INFORMATION

Name _____ , _____ DOB ____ / ____ / ____ (MM DD YY)

Address _____

City _____ State _____ ZIP _____ Phone ____ – ____ – ____

E-mail _____ Cell ____ – ____ – ____

INSURANCE INFORMATION

Patients relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other Insurance Provider _____

If other than self: Primary subscriber name? _____ Policy # _____

Group # _____

Insurance Phone ____ – ____ – ____

PHYSICIAN INFORMATION

Referring Physician _____ , _____ Phone ____ – ____ – ____

National Provider Identifier (NPI) _____ Fax ____ – ____ – ____

☐ MFM ☐ OBGYN ☐ Other: _____

Physician Address _____

City _____ State _____ ZIP _____

E-mail _____

MEDICAL INFORMATION

GRAV _____ PARTY _____ LMP _____ / _____ / _____ EDC _____ / _____ / _____ GA: weeks _____ days _____

☐ Singleton ☐ Twins ☐ Triplets Maternal Weight _____lbs

Amniocentesis

Genetic ☐ Yes ☐ No

If yes, karyotype ☐ 46,XX ☐ 46,XY ☐ Unk

Therapeutic ☐ Yes ☐ No

Medical History

Please list any pertinent medical conditions

_____

Medications

_____

INDICATION

☐ Monochorionic complications (multiples)
☐ Spina bifida
☐ Congential lung malformations
☐ Congenital diaphragmatic hernia
☐ Congenital high airway obstruction
☐ Mediastinal or pericardial teratoma
☐ Congenetal heart defects
☐ Sacroccygeal teratoma
☐ Amniotic band syndrome
☐ Lower urinary tract obstruction (LUTO)
☐ Neck mass causing airway
☐ Compression
☐ Fetal anemia
☐ Other: _____

PLEASE PRINT FORM AND FAX TO (305) 355-2415

ALL PRENATAL RECORDS, LABS, AND ULTRASOUNDS ARE REQUIRED WITH SUBMISSION

☐ Progress Notes ☐ Recent Ultrasound Reports

☐ Recent Labs ☐ Copy of Insurance Card