

**UHealth Jackson Fetal Care Center**

Consultation and/or Transfer of Care Form

Phone: 305-585-4636 | Fax: 305-355-2415

Email: MFMreferrals@jhsmiami.org



**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

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### Medications

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### INDICATION

- |  |   |
|--|---|
| <input type="checkbox"/> Monochorionic complications (multiples) | <input type="checkbox"/> Sacroccygeal teratoma                  |
| <input type="checkbox"/> Spina bifida                            | <input type="checkbox"/> Amniotic band syndrome                 |
| <input type="checkbox"/> Congenital lung malformations           | <input type="checkbox"/> Lower urinary tract obstruction (LUTO) |
| <input type="checkbox"/> Congenital diaphragmatic hernia         | <input type="checkbox"/> Neck mass causing airway               |
| <input type="checkbox"/> Congenital high airway obstruction      | <input type="checkbox"/> Compression                            |
| <input type="checkbox"/> Mediastinal or pericardial teratoma     | <input type="checkbox"/> Fetal anemia                           |
| <input type="checkbox"/> Congenital heart defects                | <input type="checkbox"/> Other: _____                           |

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

- Progress Notes  Recent Ultrasound Reports
- Recent Labs  Copy of Insurance Card