



University Health Care Center
Regional Perinatal Center
CONSULTATION REQUEST

Patient Name: _____ MR#: _____

Account #: _____ DOB: _____ Date: _____

It is imperative that all obstetrical records (sonogram reports, prenatal face sheet, applicable laboratory results) are faxed along with this referral form to Fax# (315) 464-6388. An appointment will be made after all information is received.

Contact person: _____ Referring Physician: _____

Office Phone #: (_____) _____ Ext. _____ Fax #: (_____) _____

Patient Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Work Phone: (_____) _____

Is patient pregnant? [] Yes [] No Prior PNC patient? [] Yes [] No

Does the patient speak or read English? [] Yes [] No If No, what language: _____

If No, is patient affiliated with the Refugee Center? [] Yes [] No

Insurance Name and Plan Type: _____ Preauthorization Required [] Yes [] No

Insurance ID #: _____ [] HMO Authorization #: _____

SIGNIFICANT OBSTETRICAL HISTORY

Gravida _____ Para _____ LMP Date: _____ EDC Date: _____ Weeks Gestation: _____

Indication for MFM Consult

Referring Physician's Preference: [] Consult [] Transfer of care

Indication for Genetic Referral

- 1. [] Advanced Maternal Age [] Genetic counseling only
[] Genetic counseling & amnio
2. [] Abnormal Serum Screen [] Increased Risk Down's Syndrome
[] Increased Risk Neural Tube Defect
3. Other: Please specify _____

Physician Review

(for Perinatal Center Staff use only)

Physician's Signature/Title: _____ Printed Name: _____ Date/Time: _____

PERINATAL CENTER RETURN INFORMATION

Date received: _____ (for Perinatal Center Staff use only) Received by: _____

PNC Registration: Date: _____ Time: _____ Records requested: [] Yes [] No

Ultrasound exam: Date: _____ Time: _____ Patient hand carrying records: [] Yes [] No

MFM Consult Date: _____ Time: _____ Office to send or fax: [] Yes [] No

Genetic consult: Date: _____ Time: _____ Office notified: [] Yes [] No Date: _____

Amniocentesis: Date: _____ Time: _____ Spoke with: _____

Nutrition Consult: Date: _____ Time: _____

[] New OB [] Consult Signature/Title: _____ Printed Name: _____ Date/Time: _____