PerinatalAssociates
NavicentHealthPhysicianGroup

Appointment Referral Request Form

Office Scheduling Hours- Monday-Thursday 8:00 A.M. to 4:30 P.M.

Direct Appointment Line (478) 633-0404 (Opt. #5) Records Fax (478) 742-7292

Date of Request: _____ Requesting MD: _____ Practice Name: _____

PATIENT NAME: _____

Patient Information: Demographic sheet must include the following:

- Date of Birth
- Complete Address
- SSN
- Phone: Home/cell/work
- Primary/Secondary Insurance Policy ID#
- Email address

Ultrasound Information:

Date of 1st Ultrasound_____ EGA on 1st US _____wk___d LMP_____ Current EGA_____

EDD_____ □Singleton □Twins □Triplets Pt. Weight_____ Blood Type_____

Requested Testing: (*Only those procedures checked will be performed*)

- □ Viability/Dating US
- □ 1st Trimester Screen/NT (11-13w6d)
- □ Cervical length
- □ Level II Ultrasound (18-20w, 22w if fetal echo indicated)- Indication:
  _____
  _____
  _____
- □ Biophysical Profile (BPP)
- □ Umbilical or MCA Dopplers
- □ Lab _____
- □ MD consult (and US if deemed necessary by MFM)- Indication:
  _____
  _____
  _____

Please note: A consult will be performed if an abnormality is found on our ultrasound or if another indication is present (e.g. print genetic counseling) provided records are available.

Signature of requesting MD (Required for Appt.**) _____

Please ***INFORM*** **your patient** of their appointment date/time and **remind** them that we have a **LATE POLICY**.

Scheduled Appointment(s): _____

Please attach the following records with this request: Ultrasound(s) ____ Lab(s) _____ OB flowsheet/notes ____

Consult records: _____ Blood sugar logs: _____ Other: _____