Prenatal Diagnostic Center
Maternal-Fetal Medicine

P: (405) 271-5400 F: (405) 271-5696
1200 Children's Ave Ste. 1A
Oklahoma City, OK 73104

REFERRAL SHEET

PATIENT NAME: _____	**LMP:** _____
DOB: _____	**EDD:** _____
SOCIAL SECURITY: _____	**BMI:** _____
PATIENT ADDRESS: _____	**BLOOD TYPE:** _____
HOME/CELL: _____	**PRIMARY LANGUAGE:** _____

Referring Provider: _____ **Date of Referral Request:** _____

Contact Person: _____ **Contact Phone:** _____ **Contact Fax:** _____

Urgency (circle one): 24-48 hrs 3-7 days 1-3 weeks

Indications/Diagnoses: _____

TO PROVIDE YOUR PATIENTS OPTIMAL CARE, PLEASE SEND COPIES OF THE FOLLOWING:

**PATIENT'S INSURANCE CARD, DRIVERS LICENSE FRONT AND BACK,
ALL CURRENT PRENATAL RECORDS, LAB RESULTS AND PRIOR US REPORTS**

Choose from US and/or MFM Consult then mark specific type and any counseling below

Ultrasound (w/ consult and GC if needed)

- ☐ First trimester viability *(<14 wks)*
- ☐ Nuchal translucency *(11w 0d - 13w 6d)*
- ☐ Standard anatomy (*Level 1 US*)
- ☐ Specialized anatomy (*Level 2 US*)
- ☐ Follow-up US *(e.g. Growth US)*
- ☐ Cervical Length *(16w 0d - 23w 6d)*
- ☐ Amniocentesis or CVS
- ☐ Other _____

MFM Consult (w/ US and GC if needed)

- ☐ New Consult with US exam
  - ☐ Enroll in DM/GDM Co-Management Program
- ☐ Transfer all OB care to OU MFM clinic
- ☐ Preconception counseling
- ☐ Genetic Counseling (GC)

IF ANTENATAL TESTING IS REQUIRED, WHERE SHOULD THIS BE PERFORMED? ☐ **AT OU** ☐ **AT YOUR OFFICE**

_____

TO BE COMPLETED BY OU MFM CLINIC:

MR# Assigned: _____	Faxed Clinic: _____
Appt. Date: _____	Clinic Called: _____
Appt. Time: _____	Scheduler Initials: _____
PT Notified: _____	Date: _____