AULTMAN
MATERNAL-FETAL MEDICINE
A Member of Aultman Medical Group

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REQUISITION / REFERRAL FORM

To schedule: Call (330) 363-6296 or Fax Completed form to (330) 580-6774 Website: www.AultmanMFM.com

****PLEASE FAX PATIENT INFORMATION FORM AND INSURANCE CARDS/CONSULTS: ALSO FAX ACOG PRENATAL FORMS****

MFM PHYSICIANS ARE AVAILABLE TO ASSIST IN SERVICE SELECTION

Patient Name: _____ **DOB:** ____/____/_____ **SSN:**_____

Insurance:_____ **Policy Holder DOB:** ____/____/_____**Policy Holder SSN:**_____

Yes You Can: ***Yes No Pending***

G____**P**____ **LMP:** _____**Weeks Gestation:** _____ **EDC:** _____ **By:** ☐**LMP** ☐**U/S** **Blood Type:** _____ **Interpreter Required:** ___

PRIORITY REQUEST:

___**ASAP (1-3 days)** ___ **1 week** ___ **1-2 weeks** ___ **Other (specify)** _____ **If URGENT, call MFM physician at 330-363-6296**

SERVICES REQUESTED
(Please check all that apply)

CONSULTATION

	Consultation, followed with ultrasound, as needed
	Ultrasound, followed with consultation, as needed
	Genetic Counseling
	Preconceptual Counseling
	Other: Please List

ULTRASOUND/ANTEPARTUM TESTING

	AFI (Amniotic Fluid Index)
	Amniocentesis, Ultrasound Guided
	BPP (Biophysical Profile)
	CD (Cord Doppler)
	ECHO (Fetal Echocardiography)
	MCA (Middle Cerebral Artery)
	NST (Non-stress test)
	NT Scan (Nuchal Translucency)
	OB Scan (US Obstetrical)
	TV (Transvaginal OR Cervical Length)
	OTHER: (please list)
	SCHEDULING INSTRUCTIONS:
	All Studies Conclude on EDC of _____

RAD USE ONLY
F/U: OB OB Ltd ECHO TARGETED

Due to CMS Program Memorandum A8-01-144 Change Request 1724 dated September 26, 2001, effective January 1, 2002, referring diagnosis is required for a diagnostic test. Suspected or rule-out statements are not applicable, if no confirmed diagnosis, please list

DIAGNOSIS/SYMPTOMS
(Please check all that apply)

	Abnormal Quad Screen		Multiple Gestation
	Advanced Maternal Age		Obesity BMI_____
	Anatomy		Oligohydramnios
	Dates		Polyhydramnios
	Diabetes		PTD/PTL (History of)
	Hypertension		Screening for PTL
	IUGR (Small for Dates)		Sequential Screening
	LGA (Large for Dates)		Seizure Disorder
	Medication Exposure		Size/Date Discrepancy
	Suspected Fetal Anomaly – Please List:		
	Other – Please List:		

REQUESTING PROVIDER INFORMATION

SIGNATURE: _____ ***(required)***

PROVIDER NAME: _____

PRACTICE NAME: _____

DATE: _____ **Contact Name:** _____

Phone: _____ **Fax:**_____

APPOINTMENT INFORMATION ***U/S Rm# 1 2 3***

___ **GENETIC COUNSELING**_____ _____**am/pm**
___**ULTRASOUND** _____ _____**am/pm**
___**OB CONSULT** _____ _____**am/pm**
___**PRECONCEPTUAL CONSULT** _____ _____**am/pm**

Patient Notified: Date_____ **Time** _____**Initials** _____

MFM USE ONLY: ☐**Faxed Appt** ☐**Pink Copy** ☐**QES** ☐**AS**

N O T E ➔ **You May Fax Us Your Patient Information Form Instead Of Completing the Following Information**

Patient Information		**Financial Responsibility**	
Patient Name:		Insurance Guarantor:	
Address		Address:	
Address 2		Address 2:	
City, St, ZC		City, St, ZC	
Home Phone:		Home Phone:	
Work Phone:		Work Phone:	
Cell Phone:		Cell Phone:	
Social Security No.		Social Security No.	
Birth Date:		Birth Date:	
Employer		Employer:	
Patient Account No:			
Marital Status			

	Primary Insurance	**Secondary Insurance**
Company Name		
Policy Holder Name		
Policy Holder Date of Birth		
Policy ID Number		
Group Number/Name		
Relationship to Policy Holder	Self Spouse Child Other	Self Spouse Child Other
Copay Amount		

For Internal Use

Initials of Employee Completing Form: ☐EN ☐DR ☐KR ☐ER ☐CA ☐RU

Yes You Can Required: ☐Yes ☐ No If yes, Insurance Name: _____

Yes You Can Approved: ☐Yes ☐ No

Date entered into Allscripts:

Date entered into QES:

Packet Mailed: Date: _____

Appointment Confirmed Initials: _____

Faxed to Ultrasound ☐

Faxed to Referring MD ☐

Office (Pink Book) Copy ☐