

**SSM MATERNAL & FETAL CARE CENTER
ORDER/REFERRAL**

1027 Bellevue, Suite 214
Richmond Heights, MO 63117
888-636-7642 *Perinatal Access Line*
314-622-6472 *Fax*

Date: _____ Patient Name: _____
 DOB: ___/___/___ SS#: ___ - ___ - _____
 Address: _____
 City, State, Zip: _____
 Home Phone: _____ Cell/Alternate #: _____
 Referring MD/Facility: _____ Contact name/number: _____
 Insurance: _____ Policy Holder: _____
 Policy Holder DOB: ___/___/___ Policy ID: _____
 Policy Holder Employer: _____
 Is an interpreter needed? _____ If Yes, specify language: _____
 LMP: _____ EDC: _____ G: _____ T: _____ P: _____ A: _____ L: _____ Ectopic: _____ Blood Type: _____

Indication:

Malformation Screen <input type="checkbox"/>	Bleeding <input type="checkbox"/>	Advanced Maternal Age <input type="checkbox"/>	Anomaly <input type="checkbox"/>
Small for Dates <input type="checkbox"/>	Dilated Fetal <input type="checkbox"/>	Abnormal Quad Screen <input type="checkbox"/>	Twins <input type="checkbox"/>
Large for Dates <input type="checkbox"/>	Kidneys <input type="checkbox"/>	(copy of report)	Triplets <input type="checkbox"/>
Unsure LMP <input type="checkbox"/>	Hx of Anomalies <input type="checkbox"/>	Hypertension <input type="checkbox"/>	Previous Losses <input type="checkbox"/>
Preterm Labor <input type="checkbox"/>	Oligohydramnios <input type="checkbox"/>	Polyhydramnios <input type="checkbox"/>	Diabetes/GDM <input type="checkbox"/>

Other: _____

Services Ordered:

OB Consultation only OB Consultation with co-management as indicated OB Transfer of care

Ultrasound services, please check all that apply:

- Complete obstetric ultrasound
- Fetal echocardiography
- Transvaginal obstetric ultrasound (early pregnancy/cervical length)
- Biophysical Profile / NST /
- Fetal Doppler: Type: _____ Frequency: _____
- Amniocentesis (genetic / FLM / LS / Others _____)
- Genetic Counseling
- 1st Trimester nuchal translucency with sequential screen (11-13 weeks)
- Other: _____

Physician Signature (required)

Date

Please fax all medical records including a copy of front and back of insurance card to: 314-622-6472

