UnityPoint Health Meriter | PARTNER OF UWHealth

REFERRAL TO CENTER FOR PERINATAL CARE Phone: (608) 417-6667 Fax: (608) 417-6364

Directions to Referring Clinic/Physician: Please provide the requested information **by completing each field** prior to faxing the form. If you have any questions please contact our clinic to assist you.

Patient Name: _____ UW MR#: _____	Date of Birth: _____
Previous Name(s): _____	Phone: _____
Address: _____	Insurance: _____
Interpreter: Y / N Language: _____	Member ID:_____
Referring Provider:_____ Phone:_____Fax:_____	Referral Date:_____

Patient Clinical Information- *IMPORTANT: This information must be received prior to patient's clinic visit.*

Estimated due date _____ **LMP:**_____

Dated by: ☐ LMP ☐ Dating US ☐ Other

Ultrasound date: _____

GA at time of U/S _____**Crown rump length:** _____**(cm)**

Gravida: _____**Para:** _____

Number of Fetuses:_____

BMI _____ **Ht.** _____ **Wt.** _____

☐ **URGENT- within next business day**
(Please notify us of the urgent referral by calling 608-417-6667)

Exams/Procedures **Exams below require anatomy or targeted scan at Center for Perinatal Care*	**Indication/Diagnosis code** *(required for each exam/consult ordered)*
☐ Anatomy ultrasound ☐ Targeted ultrasound **Records required prior to patient's visit:** ☐ First trimester screen ☐ Quad screen ☐ Cell free DNA Screening	
☐ Cell free DNA screening (greater than 10 weeks) ☐ First trimester screen (12-13⁴ weeks)	
☐ Chorionic villus sampling (CVS) **Blood type**_____*(Must attach lab copy)* ☐ Amniocentesis **Blood type**_____*(Must attach lab copy)*	
☐ Amniotic Fluid Index* or ☐ Biophysical profile*	
☐ Doppler study*	
☐ Fetal echocardiogram*	
☐ Growth scan* ☐ Serial Growth scans starting at _____GA*	
☐ Cervical evaluation*	
☐ Other (please describe)	
Consults	
Maternal Fetal Medicine Consult ☐ Pre-pregnancy consult ☐ Pregnancy consult without transfer of care ☐ Pregnancy consult with plan for shared care ☐ Consult with transfer of care to the CPC ☐ Fetal abnormality/concern* *(requires Targeted US and Genetic Counseling here)*	
☐ **UW Health Fetal Diagnosis and Treatment Center- Fetal Surgery Evaluation and Consultation*** *(requires Targeted US and Genetic Counseling here)*	
☐ **Genetic counseling**	
Diabetes Self-Management Education/Training *(includes medical nutrition therapy and medical management as needed)* – Indicate type of Diabetes: ☐ Type 1 ☐ Type 2 ☐ GDM ☐ Other_____ **Medical Nutrition Therapy (Dietitian only) – Indicate Diagnosis:** ☐ Multiple Gestation ☐ Healthy Nutrition ☐ Weight Management Concerns ☐ Other (Anemia, Hypertension-Dash Diet, Constipation, Renal Disease, etc.)	
☐ **Newborn Hospitalist Consult** ☐ **Anesthesia Consult**	
☐ **Fresh Beginnings Class**	

Signature/Title_____**Date:** _____