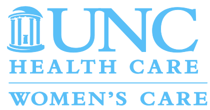

Maternal Fetal Medicine / Genetic Counseling / Ultrasound Referral Form

*THIS REFERRAL MUST BE **FULLY COMPLETED** AND ACCOMPANIED BY
(1) DEMOGRAPHIC INFORMATION (2) LEGIBLE COPY OF INSURANCE CARD FRONT/BACK
(3) PERTINENT MEDICAL RECORDS (blood type and AB screen) IN ORDER TO BE SCHEDULED*

Patient Name: (Last, First, MI) ____
Date of Birth: __________________________ Age:______ Medical Record Number: ___________________________
Patient Phone#: ________________________ Preferred Language:___________________ Interpreter Needed: Y/N
Number of Fetuses____ LMP/EDD________ Requested timeframe for appointment: ______ (days) _____ (weeks)
Requesting Provider:_______________________________ Phone #__________________ Fax# _________________
Location: ☐ Chapel Hill Campus ☐ UNC MFM @ Rex

INDICATION(S) /DIAGNOSIS CODE(S) ____
☐ v28.3 Screening for Malformations via US (for use with routine anatomy US)

Ultrasound Request

☐ **Initial ultrasound**
☐ **Repeat ultrasound**
☐ Anatomy
☐ Cervical Length
☐ Fetal growth assessment
☐ Fetal Echocardiogram
Indication _________________________
☐ Multiple Gestation: (**check one**)
☐ Twin ☐ Triplet ☐ Higher order
☐ Placenta: (**check one**)
☐ Previa ☐ Abruption
☐ Viability
☐ Suspected fetal anomaly
Describe _____________________________

Genetic Counseling with Ultrasound

☐ AMA (≥35 years/ ≥32 years with twins)
☐ Abnormal serum screening (send results)
☐ Genetic amniocentesis**: (> 15weeks)
☐ CVS* (11-13 weeks)
☐ Family History___________________________
☐ Fetal anomaly___________________________
☐ First trimester screen* (11-13 weeks)
☐ NIPT/cfDNA (> 10 weeks)**
☐ Review Genetic testing options**:
Requested at _____weeks gestation

☐ Genetic Counseling only
Indication __________________________
☐ Patient/provider declines genetic counseling
(GC required for coordination of testing)**

Antenatal Testing

☐ Amniotic fluid index
☐ Amniocentesis - Fetal Lung Maturity
☐ Biophysical Profile: (BPP)
Indication ___________________________
☐ Doppler
Indication___________________________
☐ Non Stress Test: (NST)(Chapel Hill ONLY)
Indication___________________________

Maternal Fetal Medicine Consult

☐ MFM consult only ☐ Transfer of Care
Indication ____________________________
☐ Request of co-management of patient by MFM
Indication_____________________________
☐ Preconception Consult
Indication_____________________________
☐ MFM consult with ultrasound
Indication_____________________________

By submission of this request, the referring provider authorizes Maternal Fetal Medicine consultation in the event of unanticipated findings unless otherwise directed.

Chapel Hill location: Women's Hospital First Floor
US Scheduling 984-974-6094; US Fax 984-974-9021; OB Clinic scheduling 984-974-2131
Raleigh Location: Rex Women's Birthing Center First Floor
Clinic Scheduling 919-784-6425; Clinic Fax 784-6429

**If you have any questions about the request form do not hesitate to call us. Thank you for choosing UNC Chapel Hill and UNC-REX.*