

The Fetal Center at Children's Memorial Hermann Hospital

Please fax this form along with patient medical records, including labs, ultrasounds and patient demographics, to 713.383.1464. For any questions please do not hesitate to contact our office at 832.325.7288 or toll free at 1.888.818.4818.

Date _____

Indication for referral:

G _____ P _____ | _____ | _____ | _____
EDD (by U/S or LMP) LMP Genetic testing results (if applicable)

Referring Physician:

Physician name _____

Office address _____

Phone number / Back line _____ Fax number _____

Patient Name _____

Patient address _____

Home phone _____

Primary OB: (If different from referring physician)

Physician name _____

Office address _____

Phone number / Back line _____ Fax number _____

Date of Birth _____

City _____ State _____ Zip Code _____

Cell phone _____ Work phone _____

Insurance Information:

Insurance carrier _____ Policy number _____ Group number _____ Subscriber _____

Claims address _____ Insurance carrier phone number _____

Office contact for Referral and Authorization _____

By referring to The Fetal Center you will allow us to evaluate and provide a comprehensive fetal evaluation as deemed necessary by The Fetal Center. Additional laboratory or prenatal diagnostic testing maybe ordered as clinically indicated.

Services requested (please check all that apply):

- | | |
|--|---|
| <input type="checkbox"/> Cardiology/Fetal ECHO | <input type="checkbox"/> Neurology |
| <input type="checkbox"/> Cardiovascular surgery | <input type="checkbox"/> Neurosurgery |
| <input type="checkbox"/> Fetal intervention | <input type="checkbox"/> Pediatric orthopedic surgery |
| <input type="checkbox"/> Fetal MRI | <input type="checkbox"/> Pediatric plastic and craniofacial surgery |
| <input type="checkbox"/> Fetal ultrasound | <input type="checkbox"/> Pediatric surgery |
| <input type="checkbox"/> Prenatal genetics | <input type="checkbox"/> Transfer of obstetrical care |
| <input type="checkbox"/> Maternal-fetal medicine | <input type="checkbox"/> Urology |
| <input type="checkbox"/> Nephrology | <input type="checkbox"/> Other: _____ |

Thank you for the privilege of caring for your patient

