Department of Obstetrics and Gynecology
Advanced Women's Imaging and
Prenatal Testing Center

Name:

MR #

REFERRAL FORM

First Name ____________________ Medical Record Number ____________________

Last Name ____________________ DOB ____________ Age ____________

LMP ____________ EDC ____________

Gravity ________ Parity ________ AB ________ C/S ________

Referring Provider ____________________ Phone ____________ Fax ____________

OBSTETRICAL STUDIES:

- ❑ Early pregnancy
- ❑ Ectopic pregnancy
- ❑ Level II scan
- ❑ F/U anatomical survey
- ❑ F/U scan for growth
- ❑ S<D (r/o IUGR)
- ❑ Vaginal bleeding
- ❑ Nuchal translucency/biochemical screening
- ❑ Cervical evaluation
- ❑ Placental location
- ❑ R/0 placenta accreta
- ❑ Multiple pregnancy
- ❑ Biophysical profile
- ❑ Non-stress test
- ❑ Fetal echocardiogram
- ❑ Modified Sequential Screening
- ❑ Doppler studies
- ❑ Amniocentesis (Forward Bloodtype)
- ❑ CVS - (Forward Bloodtype)
- ❑ MFPR
- ❑ Other ____________

GYNECOLOGICAL STUDIES

- ❑ Initial GYN study
- ❑ F/U GYN study
- ❑ Hysterosonogram
- ❑ Drainage of cysts
- ❑ Other ____________

CONSULTATION AND ANTEPARTUM CARE:

Please forward appropriate labwork

- ❑ MFM Consultation
- ❑ Diabetic Counseling
- ❑ Hypertension Counseling
- ❑ Anticoagulant Therapy
- ❑ Genetic Counseling

INDICATION

- ❑ Amenorrhea
- ❑ Pelvic Pain
- ❑ Fever
- ❑ Abnormal vaginal bleeding
- ❑ Enlarged uterus
- ❑ Adnexal mass
- ❑ Infertility
- ❑ Other ____________

Clinical information and suspected diagnosis:

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You have an appointment on: ____________________ at ____________ am/pm

Advanced Women's Imaging and Prenatal Testing Center
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Signature of Referring Provider