The Fetal Institute
Miami

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Date: _____/_____ /__________

Indication for Referral: ____

Patient Name: (last,first,initial): ____

DOB: ______ /______ /_______ LMP: ______ /______ /_______ EDD: ______ /______ /_______ GA: ______________

Address: ____

Home Phone: ___________________________ Mobile Phone: ___________________________

Email: ____

Insurance Information

Insurance Provider: ___________________________ Policy Number: ___________________________

Group Number: ___________________________ Phone Number: ___________________________

ULTRASOUND & CONSULT AS NEEDED

◊ First Trimester Viability Ultrasound

◊ Nuchal translucency

◊ Level II OB Anatomy Ultrasound

◊ Follow up Ultrasound

◊ Fetal Echocardiogram

◊ OB Doppler Studies

◊ Transvaginal Ultrasound

◊ 3-D OB Ultrasound

◊ Gynecological Ultrasound

◊ Telemedicine

FETAL WELL-BEING

◊ Biophysical Profile

◊ Non-stress Test

NON-INVASIVE TESTING

◊ Cell -Free DNA

INVASIVE TESTING

◊ Amniocentesis

◊ Chorionic Villus Sampling (CVS)

◊ Cordocentesis

◊ Vesicocentesis

◊ Thoracocentesis

◊ Amnioinfusion

CONSULTATION

◊ Maternal-Fetal Medicine Consult

◊ Pre-conceptional Consult

Other: ____

Ordering Physician's Name: ____

Phone Number; ___________________________ Fax: ___________________________

Ordering Physician's Signature: ____