To: **Antenatal Testing Unit**, OBGYN at Boston Medical Center

Fax: 617-638-6756

From: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referring Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referring Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Information:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Patient Name DOB Social Security # Phone #

Interpreter Need? Yes No Language:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Insurance Carrier Policy Number

Select all that apply for indication of referral below:

|  |
| --- |
| **Antenatal Testing Unit** |
| Indication for exam/Reason for referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Type of visit:* Viability/dating
* 1st Trimester Screen (Nuchal Translucency)
	+ I counseled the patient on the option for aneuploidy screening and the patient consents for this testing, which will be ordered at the first trimester ultrasound

**YES\_\_\_\_\_\_\_ / NO\_\_\_\_\_\_\_*** Fetal Survey (Level II U/S)
* Non-stress test
* Non-stress test (with AFI)
* Cervical Length
* Growth (EFW)

Scheduling Priority:* Urgent: 24-48 hours\*
* Urgent: 1-2 weeks
* Routine: 2 weeks or >
 |

**PREGNANCY INFORMATION:**

LMP \_\_\_/\_\_\_/\_\_\_ EDC \_\_\_/\_\_\_/\_\_\_ if by ultrasound: date: \_\_\_/\_\_\_/\_\_\_ GA at ultrasound \_\_\_ wks\_\_\_days G\_\_\_\_\_\_\_P\_\_\_\_\_\_\_

* Singleton Gestation
* Multiple Gestation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

THIS PREGNANCY COMPLICATED BY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PREVIOUS PREGNANCY COMPLICATED BY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***\*Has the patient been seen at BMC for this pregnancy before? (please circle)*** **YES NO**

**INCLUDED WITH THIS FORM, PLEASE FAX ALL RELEVANT MEDICAL RECORDS**

\*PLEASE NOTE- Separate referrals must be submitted for obstetrics, antenatal testing unit and genetic counseling respectively\*