THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

Maternal Fetal Medicine (MFM) Referral Form

Indicate if URGENT referral needed (typically scheduled within one week): ☐ YES

Instructions

Please fax this form along with a copy of your patient's prenatal records (blood type, any labs pertaining to condition, ultrasound reports, obstetric surgery reports and all genetic screening results) and a copy of their insurance card to 614-293-2200.

Demographics

Patient name:

Date of birth:

Social security number:

Mobile phone:

Home phone:

Estimated date of confinement (EDC):

Last menstrual period (LMP):

Address:

Insurance company:

Height:

Weight:

Please check all services requested

- If you want the MFM provider to discuss any medical/obstetrical conditions, please check consult or co-manage box.
- The MFM physician will provide consultation for ALL ultrasounds (when needed). A separate consultation doesn't need to be ordered to review the ultrasound findings.

Ultrasound only

☐ US OB 1st tri-NT 12-13.3 wks.
☐ US OB dating abdominal < 14 wks.
☐ US OB anatomy > 18 wks.
☐ Other (specify):
☐ US OB detailed anatomy > 18 wks.
☐ US OB fetal growth > 14 wks.

1800 Zollinger Road, 4th Floor, Columbus, OH 43221
Phone: 614-293-2222, Fax: 614-293-2200

MFM and ultrasound

- ☐ MFM consult
- ☐ Co-manage care with MFM
- ☐ Total assume care by MFM (this care model includes a team of trainees and nurse practitioners)

Must also order an ultrasound

- ☐ US OB dating abdominal < 14 wks.
- ☐ US OB anatomy > 18 wks.
- ☐ US OB detailed anatomy > 18 wks.
- ☐ US OB fetal growth > 14 wks.

Additional procedures requested to be scheduled with Ohio State MFM:

- ☐ All follow-up growth ultrasounds *(if indicated)*
- ☐ Antenatal testing *(select only if planning delivery at Ohio State and unable to perform in primary OB office or local hospital)*
- ☐ Delivery

Genetics

- ☐ Prenatal genetic counseling (GC)
- ☐ Preconception GC
- ☐ Amniocentesis*
- ☐ Chorionic villus sampling*

**Genetic counseling required*

Alloimmunization

- ☐ Alloimmunization committee will determine need for labs +/- consult and place orders.

Referral reason

- ☐ Maternal age > 35
- ☐ Diabetes mellitus (prior to pregnancy)
- ☐ History of preterm birth
- ☐ Other (specify):

- ☐ Abnormal screening
- ☐ Gestational DM (include one- and three-hour results)
- ☐ Hypertension
- ☐ Preconception
- ☐ Multiple gestation (specify):

Referring provider info

Referring provider signature:

Printed name: **Date:**

Phone: **Fax:**

Address:

MFM Office Use Only

Received:

Scheduled for: