Physician Order

Saint Luke's Health System

Maternal Fetal Medicine Specialists

Date of Request:_____

Ordering Physician:_____ Contact Phone:_____

WHAT WE NEED FROM YOU: **(BEFORE WE CAN SCHEDULE YOUR PATIENT)**

☐ Completed referral form

☐ Copy of insurance card

☐ Prenatal records, including labs, ultrasound reports, genetic testing results

☐ Interpreter needed? Language:_____

Patient Name:_____ DOB:_____

Home Address:_____

Phone Number:_____ Email:_____

Insurance Name:_____

Policy/ID:_____ Phone:_____

Gravida/Para:_____ LMP:_____ EDD:_____ Current gestational age:_____

Maternal Diagnosis:_____

Fetal Diagnosis:_____

Anticipated number of births (please select one): ☐ Single ☐ Twins ☐ Triplets

SERVICES REQUESTED
(Please mark all that apply)

☐ MFM Consult

☐ Heart Conditions in Pregnancy Program ☐ Diabetes in Pregnancy Program
(send lab results for CBC, Iron Studies, TSH and BMP)

☐ Preconception Consult

☐ Transfer of Care

☐ Ultrasound
- ☐ 1ST Trimester
- ☐ Nuchal Translucency
- ☐ Anatomy Ultrasound
- ☐ Growth/Follow Up
- ☐ Fetal Echocardiogram
  - ☐ Need MFM to perform detailed ☐ Detailed US results included

☐ Diagnostic Genetic Testing
- ☐ Amniocentesis
- ☐ CVS

☐ Antepartum Testing
- ☐ Biophysical Profile
- ☐ Biophysical Profile with NST
- ☐ NST Only

☐ Schedule Services based upon MFM Physician Recommendation ☐ Yes ☐ No

Questions: please call 816-932-3585

PLEASE FAX ALL OF THE ABOVE DOCUMENTS TO 816-932-5137

Patient Label:

SYS-2199 (Rev. 03/18/24)