Maternal Fetal Medicine and Genetics

Susan Ponkey, MD

Referral Form

Patient name_____ DOB_____

Phone_____ EDC_____

Insurance_____ ID#_____ Group#_____

Referring Provider_____ Fax_____

Diagnosis_____

_____

Special scheduling: ☐ STAT Delay appointment until_____

☐ Ultrasound (with consult as indicated)
☐ Fetal echo (with consult as indicated)
☐ Consult (with ultrasound as indicated)
☐ Genetic consult/testing (with ultrasound as indicated)
☐ Diabetic consult (with ultrasound) ☐ Co-management
☐ Preconception consult
☐ Fetal testing ☐ Twice weekly Other_____
☐ Amniocentesis/CVS

Any specific requests_____

Please fax initial DATING ULTRASOUND, any aneuploidy/DOWN SYNDROME screening, GENETIC CARRIER screening (i.e. cystic fibrosis) and AFP results, as well as any other relevant records to 480-773-6512.

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