Ohio Fetal Medicine Collaborative

Referral Form

Nationwide Children's Hospital
Fetal Medicine Department
Fax: 614-355-4445
Phone: 614-722-6520

Demographics	
Patient's Name: **DOB:**	**Best way to reach Patient: Phone Number** (H) (C)
Address:	**Interpreter Needed: Yes/No** **Language:**
Support Person/Significant Other:	**Copy of Demographics Attached: Yes/No**
Provider Information	
Referring MFM Provider	**Phone Number** **Fax Number**
Primary Obstetrician	**Phone Number** **Fax Number**
Insurance	
Primary Insurance	**Copy of Insurance Card attached: Yes/No**

Clinical Information			
Fetal Diagnosis:			
Other Concerns:			
Gravida/Para	**EDC**	**Current GA**	**Number of Fetuses**
Genetic Counselor Visit: Yes/No **Genetic Testing Yes/No** **Amniocentesis** **CVS:** **CFDNA:**		**Genetic Results:** **Karyotype:** **Microarray:**	
Prenatal records and most recent ultrasound attached: Yes/No			

Fetal Medicine Consults

☐ **Cardiology** ☐ **Craniofacial** ☐ **Genetics** ☐ **Nephrology**
☐ **Neonatology** ☐ **Neurosurgery** ☐ **Neurology** ☐ **Orthopedics**
☐ **Pediatric Surgery** ☐ **Palliative Care** ☐ **Urology** ☐ **Other:**

Fetal Diagnostic Orders

☐ **Fetal MRI:**	**Orders signed by MD**	**Yes**	**No**
	Pre-certification complete	**Yes**	**No**
☐ **Fetal Cardiac Echo:**	**Echo Form Completed & Signed by MD**	**Yes**	**No**
	Pre-certification completed	**Yes**	**No**