MUNSON HEALTHCARE

Form # 11808 (09/19)

MUNSON MATERNAL FETAL MEDICINE REFERRAL

11808

Patient Demographics	Referring Physician
Patient's Legal Last Name:	Physician (print name):_____
First Name:	Referring office phone number:_____
Middle:	Referring office fax number:_____
Date of Birth: _____/_____/_____	Date Ordered:_____
Address:_____	
_____	
Phone Number:	
Alternate Phone Number:	(Office Stamp here)

Pregnancy Details	Services Requested
LMP:	☒ **MFM PHYSICIAN CONSULTATION AND ULTRASOUND**
EDC:	☐ Preconception Consult
Gravida: Para:	☐ Fetal Echocardiogram (approx. 22 weeks)
Current G.A. _____ weeks	☐ Follow up as recommended by MFM Clinic: AFI Doppler, Fetal Growth, Fetal Echo, MCA Dopplers, Biophysical Profile (BPP), Cervical length, Non-Stress Test (NST)

Referral Indication/Diagnosis: _____

_____

Associated ICD-10 Codes: _____

Scheduling Requests:

☐ 18 - 20wk detailed anatomy ☐ Next available ☐ Urgent

☐ Other: _____

_____ _____ _____

Referring Physician Signature Date Time

Prior to scheduling an appointment, we require patient demographics, prenatal history and physical, labs, ultrasounds and any pertinent medical records to support the referring indication.

Please fax to desired location:

☐ Traverse City Clinic
Phone #: 231-392-8280
Fax #: 231-935-2127

☐ Manistee Clinic
Phone #: 231-398-1550
Fax #: 231-398-1691

☐ Cadillac Clinic
Phone #: 231-876-6100
Fax #: 231-392-7380

PATIENT ID LABEL HERE