

**Prenatal & Preconception Appointment Request Form**

Please fax or email this completed form **AND** supplemental records to (603) 663-3386 or [faxmfm@elliott-hs.org](mailto:faxmfm@elliott-hs.org).

**\*\*\* For all patients, please fax OB records, dating information, ultrasounds, genetic screening results, blood type, and MCV\*\*\***  
Incomplete forms or missing information may delay appointment scheduling

Referring Provider \_\_\_\_\_

Practice Name \_\_\_\_\_

Patient Name \_\_\_\_\_

Date of Birth \_\_\_/\_\_\_/\_\_\_

Preferred Phone Number \_\_\_\_\_

or Email \_\_\_\_\_

**\*\*Please attach patient demographic sheet and insurance information. This is required to register the patient\*\*\***

Interpreter needed?  Yes  No Language \_\_\_\_\_

Currently Pregnant?  Yes  No Seen Elliot MFM Before?  Yes  No Is Patient Aware of this Request?  Yes  No

EDD \_\_\_/\_\_\_/\_\_\_ based on:

LMP \_\_\_/\_\_\_/\_\_\_  US \_\_\_/\_\_\_/\_\_\_ @ \_\_\_ wks GA  Embryo transfer \_\_\_/\_\_\_/\_\_\_ @ \_\_\_ days

Gravida \_\_\_\_ Para \_\_\_\_ Term \_\_\_\_ Preterm \_\_\_\_ SAB \_\_\_\_ TAB \_\_\_\_ Living \_\_\_\_

Pre-gravid BMI \_\_\_\_\_ Blood Type \_\_\_\_\_

**Indication for Referral (please describe):**

- |   |  |  |  |  |
|---|--|--|--|--|
| <input type="checkbox"/> Routine Pregnancy  | <input type="checkbox"/> Abnormal Ultrasound Finding | <input type="checkbox"/> Positive Screening  | <input type="checkbox"/> Advanced Maternal Age | <input type="checkbox"/> IVF pregnancy         |
| <input type="checkbox"/> Obesity BMI ≥30  | <input type="checkbox"/> Obesity Class III BMI ≥40   | <input type="checkbox"/> Medication Exposure | <input type="checkbox"/> Placenta Problem      | <input type="checkbox"/> Bleeding in Pregnancy |
| <input type="checkbox"/> Multiple Gestations  | <input type="checkbox"/> Recurrent Pregnancy Loss    | <input type="checkbox"/> TOLAC/VBAC          | <input type="checkbox"/> Isoimmunization       | <input type="checkbox"/> Late Prenatal Care    |
| <input type="checkbox"/> Family Hx (circle): Genetic Disorder Congenital Heart Disease Congenital Anomaly                                 |  |  |  |  |
| <input type="checkbox"/> Maternal conditions (circle): CHTN DM GDM SUD Thyroid Autoimmune Condition Cardiac Disease Uterine Anomaly Other |  |  |  |  |
| <input type="checkbox"/> Complication in Prior Pregnancy (circle): PTD PPROM Preeclampsia FGR Cervical Insufficiency Other                |  |  |  |  |

Other: \_\_\_\_\_

Details \_\_\_\_\_

**Services Requested:**

**Genetic Counseling**

- Consultation
- NIPT
- Carrier Screening

**Maternal Fetal Medicine**

- Consultation
- CVS (Chorionic Villus Sampling)
- Amniocentesis

**Ultrasound (Includes MFM visit to review results)\***

- 1<sup>st</sup> Trimester/Dating  Nuchal Translucency  1<sup>st</sup> Trimester Detailed Anatomy
- Routine Low Risk Anatomy  Early Detailed Anatomy  Detailed High Risk Anatomy
- Growth  Biophysical Profile  Cervical Length
- Screening Fetal ECHO (IVF, DM HgbA1c < 7, NT 3-3.5, SSA/SSB+, Medication Exposure)

Other: \_\_\_\_\_

\*High-risk ultrasound is followed by MFM visit to review results, if MFM follow up is recommend this will be scheduled unless indicated.

\*Please check MFM consult if a full consultation is desired with ultrasound visit.

\*US referrals without prior anatomy survey in our office will also receive anatomy scan unless otherwise specified.

For other options check here:

- READ ONLY US – Ordering provider is responsible for result interpretation, follow up orders and pregnancy management.
- US and MFM visit without scheduled follow up. -Ordering provider is responsible for follow up orders and pregnancy management.
- US as ordered without additional anatomy scan views. – Ordering provider responsible for ensuring adequacy of outside anatomy scan

Ordering Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**THANK YOU FOR CHOOSING ELLIOT MFM!**