

Maternal Fetal Medicine

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Patient Name:	EDC:
Referring Physician/Signature:	
Phone:	Fax:
Reason for Referral:	
	t medical records/lab results* ns and directions located on the website*
CONSULTATIONS	ULTRASOUND
MFM consultation, ultrasound as	☐ First trimester dating ultrasound
indicated	■ Nuchal Translucency Screening
☐ Diabetic teaching and management	☐ Fetal anatomy scan
☐ Preconception counseling	☐ Growth ultrasound
Genetic consultation	☐ Fetal echocardiogram
☐ Universal carrier screening (Counsyl,	Transvaginal ultrasound for
includes genetic consultation)	cervical length
☐ Noninvasive prenatal screening	Consultation as indicated
(cell free fetal DNA, includes genetic	
consultation)	OTHER SERVICES
	☐ BPP
<u>PROCEDURES</u>	☐ Modified BPP (AFI and NST)
☐ Amniocentesis	□ NST

Amniocentesis

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