# Referral Form
# Maternal Fetal Medicine

PERINATAL Center of Florida

**PLEASE FAX REFERRAL FORM TO 954-447-2708 / 954-322-8984**

**OR EMAIL: PCFMIRAMAR@SHCR.COM**

Date: _____ Contact: _____ Referring OB: _____

Office Phone: _____ Fax: _____

First Name: _____ Last Name: _____ DOB: _____

Address: _____ City _____ : Zip Code: _____

Cell #: _____ Alt #: _____ Age: _____

SSN: _____ Email: _____

G: _____ P: _____ A: _____ Living: _____ EDC: _____ LMP: _____

Insurance: _____ Phone _____ Member I.D: _____

Authorization #: _____ Visits Allowed: _____ Exp. Date: _____

**PERINATOLOGY CONSULTATION**
- ☐ Medical Condition
- ☐ Preconception Counseling
- ☐ Other _____

**DIABETES CO-MANAGEMENT**
- ☐ Gestational Diabetes
- ☐ Pre-gestational Diabetes

**HYPERTENSION CO-MANAGEMENT**
- ☐ Chronic hypertension
- ☐ Pre-eclampsia

**ULTRASOUND**
- ☐1st trimester screen
- ☐Anatomy survey
- ☐Abnormal serum screen
- ☐Multifetal gestation
- ☐Placenta anomalies
- ☐Amniotic fluid abnormalities
- ☐Morbid obesity
- ☐Fetal Growth
- ☐Other:

_____

**FETAL TESTING**
- ☐Amniocentesis
- ☐Biophysical profile
- ☐NST
- ☐Other:

_____

**GENETIC COUNSELING**
- ☐ Advanced Maternal Age
- ☐ Positive maternal serum screen
- ☐ Fetal anomaly
- ☐ Medication exposure
- ☐ Previous child with:

_____
- ☐ Family History of:

_____
- ☐ Recurrent pregnancy losses
- ☐ Other:

_____

Other medical condition or additional info: _____

_____

_____

*****Please include authorization and relevant medical records *****

☐ **Miramar**
1951 SW 172nd Ave
Suite 309
Miramar FL, 33029

**Perinatal Center of Florida**
**Tax ID 65-0363303**

☐**Hollywood**
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Suite 550
Hollywood FL 33021