almara.
women's health

Patient Referral

Edina Maternal Fetal
6545 France Ave • Suite 510 • Edina MN 55435
Call Direct | 952.285.3880

PATIENT NAME _____

DOB _____

PHONE _____

NEED INTERPRETER ☐ Y ☐ N LANGUAGE _____

Indication/Reason for Referral

REASON _____

EDD _____ LMP _____

PATIENT BMI _____

PLEASE CHECK ☐ SINGLE ☐ TWIN ☐ TRIPLET ☐ QUAD

Consultation

REASON FOR CONSULTATION REQUEST _____

_____

☐ MATERNAL FETAL MEDICINE CONSULT

☐ GENETIC COUNSELING CONSULT

Ultrasound

☐ FIRST TRIMESTER ULTRASOUND (LESS THAN 14 WEEKS GESTATION)

☐ TRANSVAGINAL ULTRASOUND FOR CERVICAL LENGTH ASSESSMENT

☐ DETAILED (COMPREHENSIVE) ULTRASOUND (18+ WEEKS GESTATION)

☐ OTHER SPECIFIC REQUEST _____

Fetal Echocardiogram*

☐ FETAL ECHOCARDIOGRAM

☐ MATERNAL FETAL INDICATION ☐ FETAL INDICATION

*Often scheduled after completion of Detailed Ultrasound

Fetal Surveillance

REASON FOR FETAL SURVEILLANCE _____

_____

☐ BIOPHYSICAL PROFILE WITHOUT NST

☐ BIOPHYSICAL PROFILE WITH NST ☐ NON-STRESS TEST (NST)

*Patient may proceed with recommendations for further testing as directed by MFM Physician

CLINIC INFORMATION

DATE _____

PRENATAL PROVIDER SIGNATURE _____ PRINTED NAME _____

REFERRING CLINIC _____ CLINIC CONTACT _____
NAME

Please send patient's demographic and insurance information, along with any applicable records (prenatal records, prenatal labs, consultation notes, ultrasound reports).

_____ _____
PHONE NO. FAX NO.