WASHINGTON UNIVERSITY
MATERNAL-FETAL MEDICINE

ULTRASOUND REFERRAL ORDER FORM FOR **NON-EPIC USERS**

Please fax required documents prior to scheduling to:
314-747-1637
☐ This form ☐ Insurance card (front and back)
☐ Medical records
If no response within 48 hours, please call 314-454-8181.

PATIENT NAME *(last, first, M.I):*		Date of birth:
Interpreter ☐ Yes - If yes, language:	☐ No	
Patient address:		
Patient home phone:	Patient alternate phone:	
Required Insurance name (plan name):		
Name of policy holder:		
Policy ID #:	ID#:	Relationship to insured:

Referring physician:	Office contact person:
Office phone #:	Office fax #:
Primary obstetrician, if not referring physician:	

Preferred scan location: ☐ BJH - Center for Outpatient Health ☐ Missouri Baptist Medical Center ☐ Progress West Hospital ☐ Shiloh, IL* ☐ South County - Center for Advanced Medicine

Indication for referral (DX):

GYNECOLOGIC ULTRASOUND ☐ TA and/or TV ☐ SIS (Saline Infusion Sonography)

OBSTETRIC ULTRASOUND			
	LMP:	EDD:	EDD based on LMP/Ultrasound/Other:
	BMI:	Number of fetuses:	

☐ Rule out Ectopic/PUL ☐ Viability/Dating < 14 weeks

☐ First Look (11-13.6 weeks) – Nuchal Translucency measurement / Include counseling: ☐ Yes ☐ No

☐ Standard (gestational age assignment/anatomic survey) (19–20 weeks) with transvaginal if < 24 wks

☐ Specialized (Including, but not limited to: known or suspected anatomic or genetic abnormality or increased risk for same; AMA; IDDM; drug exposure; presence of ultrasound markers; MC twins) with transvaginal if < 24 wks

☐ Growth/Repeat (re-evaluation fetal size and/or re-examination of specific organs(s) known or suspected to be abnormal)

☐ Biophysical profile (NSTs performed only at Center for Outpatient Health and Missouri Baptist Medical Center)

☐ Cervical length ☐ Umbilical and/or fetal doppler

☐ Limited – AFV, fetal position, placental location, FHM, rule out ectopic, other:

DIAGNOSTIC TESTING ☐ Amniocentesis (15–20 weeks) ☐ CVS (10–13 weeks) ☐ Fetal lung maturity
(Authorization may be required, please verify with the insurance company. Blood type is required.)

GENETIC COUNSELING ☐ Pre-conception counseling ☐ First Look counseling ☐ Counseling with diagnostic testing

Please list indication (abnormal serum screen, personal/family history of heritable condition, cell-free fetal DNA testing, etc):

MATERNAL-FETAL MEDICINE	Indication for referral (DX):

☐ Pre-pregnancy consult ☐ OB consult ☐ Co-management of care ☐ Transfer of care ☐ Fetal care

Required - Physician signature:	Date:

**Specialty services provided by Washington University Physicians in Illinois, Inc*