

**WASHINGTON UNIVERSITY  
MATERNAL-FETAL MEDICINE AND ULTRASOUND  
REFERRAL ORDER FORM**

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.

The most current version of this form can be found at:

[obgyn.wustl.edu/patients/ultrasound-genetics/screening-patient-forms/](http://obgyn.wustl.edu/patients/ultrasound-genetics/screening-patient-forms/)

PATIENT NAME (last, first, M.I):		Date of birth:	
Interpreter <input type="checkbox"/> Yes - If yes, language:		<input type="checkbox"/> No	
Patient address:			
Patient home phone:		Patient alternate phone:	
<b>*Required*</b> 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: <input type="checkbox"/> BJH - Center for Outpatient Health <input type="checkbox"/> Missouri Baptist Medical Center <input type="checkbox"/> Progress West Hospital <input type="checkbox"/> Shiloh, IL* <input type="checkbox"/> Maryville, IL*(Internal only) <input type="checkbox"/> Mt. Vernon, IL*(Internal only) <input type="checkbox"/> Carbondale, IL (Telemedicine)			
Indication for referral (DX):			
GYNECOLOGIC ULTRASOUND <input type="checkbox"/> TA and/or TV <input type="checkbox"/> SIS (Saline Infusion Sonography)			
OBSTETRIC ULTRASOUND	LMP:	EDC:	EDC based on LMP/Ultrasound/Other:
Number of fetuses:			
<input type="checkbox"/> Rule out Ectopic/PUL <input type="checkbox"/> Viability/Dating < 14 weeks <input type="checkbox"/> First Look (11-13.6 weeks) – Nuchal Translucency measurement / Include counseling: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Standard (gestational age assignment/anatomic survey) (19–20 weeks) with transvaginal if < 24 wks <input type="checkbox"/> 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 <input type="checkbox"/> Growth/Repeat (re-evaluation fetal size and/or re-examination of specific organs(s) known or suspected to be abnormal) <input type="checkbox"/> Biophysical profile (NSTs performed only at Center for Outpatient Health and Missouri Baptist Medical Center) <input type="checkbox"/> Cervical length <input type="checkbox"/> Umbilical and/or fetal doppler <input type="checkbox"/> Limited – AFV, fetal position, placental location, FHM, rule out ectopic, other:			
<b>DIAGNOSTIC TESTING</b> <input type="checkbox"/> Amniocentesis (15–20 weeks) <input type="checkbox"/> CVS (10–13 weeks) <input type="checkbox"/> Fetal lung maturity <i>* Authorization may be required, please verify with the insurance company. Blood type is required.</i>			
<b>GENETIC COUNSELING</b> <input type="checkbox"/> Pre-conception counseling <input type="checkbox"/> First Look counseling <input type="checkbox"/> Counseling with diagnostic testing Please list indication (abnormal serum screen, personal/family history of heritable condition, cell-free fetal DNA testing, etc):			
<b>MATERNAL-FETAL MEDICINE</b>		Indication for referral (DX):	
<input type="checkbox"/> Pre-pregnancy consult	<input type="checkbox"/> OB consult	<input type="checkbox"/> Co-management of care	<input type="checkbox"/> Transfer of care <input type="checkbox"/> Fetal care

Required - Physician signature:	Date:
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\*Specialty services provided by Washington University Physicians in Illinois, Inc