In order to avoid delays in patient care, please refer as soon as possible and complete all fields. Please include the following information with the referral:

- **Demographics face sheet**
- **Medical Records**
- **Labs**
- **Ultrasound Report**

Grant Scott Bonham

Fetal Center & Fetal Heart Program

Patient Referral

Phone: 801-662-6474
Fax: 801-442-0570
PC-utahfetalcenter@imail.org

Intermountain® Primary Children's Hospital | HEALTH UNIVERSITY OF UTAH

Patient Name: _____ Maiden Name: _____ DOB:_____

Address: _____ City: _____ State: _____ Zip:_____

Cell Phone: (_____)_____ Home Phone: (_____)_____ Email:_____

Referral Indication:_____

Additional Diagnoses/Comments:_____

Scheduling Timeframe:_____

EDD:_____ LMP:_____ Singleton: _____ Twins:_____ Other:_____ Interpreter: Y/N If yes, Language:_____

Referring Provider:_____ Name of Practice:_____

Direct Phone:(_____)_____ Fax:(_____)_____Email: _____

Address: _____ City: _____ State:_____ Zip: _____

Primary Provider:_____ Name of Practice:_____

Phone: (_____)_____ Fax: (_____) _____ Email: _____

Address: _____ City: _____ State:_____ Zip: _____

Insurance: _____ Policy #: _____ Group #: _____

Phone: (_____)_____ Subscriber: _____ Subscriber's DOB: _____

Claims Address:_____

Consultation and imaging reports will be available in the Intermountain system and faxed to your office. If you would like to receive a phone call from the consulting physician, please provide information below:

Name:_____ Phone: (_____)_____ Fax: (_____)_____

If there is an additional care provider that you would like to receive the consult and imaging report, please provide that information below:

Name:_____ Phone: (_____)_____ Fax: (_____)_____