UTAH FETAL CENTER REFERRAL FORM

Date

Referring physician name (OB/GYN and/or subspecialist) | Office phone | Office fax

Practice contact | Office phone | Office fax

Patient name | E-mail address

Patient address

Patient phone | Alternate phone

Translator needed? If yes, what language?

Primary insurance carrier | Phone | Policy number | Group number | Subscriber

Secondary insurance carrier | Phone | Policy number | Group number | Subscriber

Indication for referral | Gestational age | LMP | EDD

Services requested (please check all that apply):

- ☐ Comprehensive fetal evaluation as deemed necessary by the Utah Fetal Center
- ☐ Consultation with specific Fetal Center Faculty:
  - ☐ Fetal MRI
  - ☐ Fetal ultrasound
  - ☐ Transfer of care (pending approval)
  - ☐ Cardiology/Echocardiogram
  - ☐ Craniofacial surgery
  - ☐ Evaluation for Fetal Intervention
  - ☐ Genetics Counseling
  - ☐ MFM consultation
  - ☐ Neonatology
  - ☐ Nephrology
  - ☐ Neurology
  - ☐ Neurosurgery
  - ☐ Palliative Care (Rainbow Kids)
  - ☐ Pediatric Surgery
  - ☐ Social Services
  - ☐ Urology
  - ☐ Other: _____

Ref Ltr50091

Consultation and imaging reports will be available in the Intermountain system and faxed back to your office as quickly as possible. In addition to these written materials, would you also like to receive a phone call from the consulting physician? If yes, please provide information below:

Name _____ Fax _____ Phone _____

Is there an additional care provider (e.g primary OB/GYN) that you would like us to include in post-consult communication? If yes, please provide information below:

Name _____ Fax _____ Phone _____

Please fax these forms, along with all patient's medical records including labs, ultrasounds and demographic info, to 801-442-0570. Thank you for your referral.

Intermountain Primary Children's Hospital
The Child First and Always®

The University of Utah School of Medicine