

Comprehensive Fetal Care Center

****Temporary patient referral form****



Dell Children's Specialty Pavilion
4910 Mueller Blvd, Suite 103
Austin, TX 78723

Please fax this form along with patient medical records, including labs, ultrasounds and patient demographics to **512-324-0041**. For any questions, please do not hesitate to contact our office at **512-324-0040**.

Date: _____

Indication for referral

Referring diagnosis: _____

G: _____ P: _____ EDD: _____ by U/S or LMP (circle one) LMP: _____ Genetic testing results (if applicable)

Patient information

Patient name: _____ Patient DOB: _____

Patient address: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Physician information

Physician name: _____ Office address: _____

Phone number/back line: _____ Fax number: _____

Primary OB: _____ Office address: _____
(if different from referring physician)

Phone number/back line: _____ Fax number: _____

Insurance information

Insurance carrier: _____ Policy number: _____

Group number: _____ Subscriber: _____ Insurance carrier phone number: _____

Claims address: _____ City: _____ State: _____ Zip: _____

Services requested (please check all that apply):

- | | | |
|--|---|---|
| <input type="checkbox"/> Cardiology/Fetal ECHO | <input type="checkbox"/> Nephrology | <input type="checkbox"/> Pediatric surgery |
| <input type="checkbox"/> Cardiovascular surgery | <input type="checkbox"/> Neurology | <input type="checkbox"/> Prenatal genetics |
| <input type="checkbox"/> Fetal intervention | <input type="checkbox"/> Neurosurgery | <input type="checkbox"/> Transfer of obstetrical care |
| <input type="checkbox"/> Fetal MRI | <input type="checkbox"/> Pediatric orthopedic surgery | <input type="checkbox"/> Urology |
| <input type="checkbox"/> Fetal ultrasound | <input type="checkbox"/> Pediatric plastic and craniofacial surgery | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Maternal-fetal medicine | | |

Translation services

Non-english speaking If so, please provide your preferred language: _____

Office contact for referral and authorization

By referring to The Comprehensive Fetal Care Center you will allow us to evaluate and provide a comprehensive fetal evaluation as deemed necessary by The Comprehensive Fetal Care Center. Additional laboratory or prenatal diagnostic testing may be ordered as clinically indicated.

Thank you for the privilege of caring for your patient.

