Fetal-Maternal Center Referral Form

Thank you for your referral!
Please fax this form to us at:

Fax: 323-361-6069

Questions? Please contact Elizabeth Gonzalez
Phone: 323-361-6078

Date: _____/_____/_____

SELECT THE FOLLOWING SERVICES NEEDED (please check all that apply):

☐ FMC/CHLA Full Access
Includes perinatology services, pediatric subspecialty consultation as needed, an RN Care Manager, any diagnostic imaging and testing necessary, and delivery coordination.

☐ Perinatology Second Opinion Consult
Includes FMC perinatology consult partnering with referring OB and/or referring perinatologist.

☐ Pediatric Subspecialty Service Consult
Please note: all pediatric subspecialty consults include a FMC perinatologist for evaluation of findings.

☐ Fetal ECHO (test results are sent to referring provider)

☐ Fetal MRI (requires visit with FMC Perinatologist)

☐ Transfer of OB Care
Referring OB request transfer of OB care for remainder of pregnancy and delivery.

REFERRING PHYSICIAN INFORMATION

MFM: _____ Office Phone #: _____ Fax #: _____

OB: _____ Office Phone #: _____ Fax #: _____

PATIENT INFORMATION

Patient Name: _____

Date of Birth: _____ Phone #: _____ EDC: _____

REQUESTED DOCUMENTATION

Please attach the following information:

- Patient demographic information
- Ultrasound reports, consults, diagnostic reports/results, labs, 1st & 2nd trimester screening results
- Other relevant clinical information
- Complete ACOG records with original labs (if transfer of OB Care)
- Patient insurance information
  - Insurance Authorization must be completed before the first appointment can be scheduled
  - **Questions? Contact: Cindy Amaya at 323-361-7042**

ACCEPTANCE OF PATIENT

- Once requirements on this form are completed, the first appointment will be scheduled.