New Patient Referral/Physician Order for BCH MFCC

Please fill out **ALL** fields and fax to (617) 730-0124 or email (MFCCReferrals@childrens.harvard.edu).

Please ensure that the form is signed and dated by the ordering clinician (bottom of page).

For all questions, please call the Maternal Fetal Care Center at (617) 355-6512

Patient Information:

Full Name: ___________________________________ Maiden Name: ______________________________ DOB: __________________

Home Address: ____ City: _____________________ State: _______ Zip: _____________

Phone Number: (___) __________________ Cell Phone: (___) ___________________ Email: ______________________________

Interpreter (Y/N): ____________ If Yes, Language: _________________________________

Indication/Diagnosis: ____

Current anticipated delivery location: _________________________________ Prior pregnancy/child care at BCH: _____

EDC: ______________________ Current Gestational Age: ____________ Singleton: _____ Twins: _____ Other: _____

PCP: ____ (Required for insurance purposes)

Insurance Company: ________________________ Plan Name: ____________________ Insurance ID Number:

Referring Physician Information:

Physician Name: ___________________________________ Physician Specialty: □OB □MFM □Cardiologist □Other

Practice Name: _______________________________________ Physician Email: ___________________________________

Physician Phone Number: (___) ______________ Practice Fax Number: (___) ___________________________

Address: ______________________________________ City: _____________________ State: _______ Zip: _________

Primary OB (if Different): ___________________________________ Physician OB Email: ______________________________

Practice Name: ____________________________ Phone Number: (___) ______________ Fax Number: (___) ________________

Address: ____ City/State: ______________________________ Zip: ______________

Items to Include:

- Demographic sheet with Insurance Information
- ALL records and imaging reports from this pregnancy
- Lab work, genetic testing, amnio results
- Prenatal early screening results
- CD of images (if applicable)

Requested Appointments/Physician Order:

☐ Fetal Echo ☐ Fetal Ultrasound
☐ Fetal MRI ☐ Consult _________
☐ MFM Consult ☐ Consult _________
☐ Other (Please specify) _________ ☐ **Fetal Intervention**

Requested Timeframe Schedule:

Please understand that appointments will be scheduled based on availability, as well as triaged clinical severity.

□ **CHECK THIS BOX to refer to Boston Children's Hospital MFCC for evaluation and treatment including diagnostic testing.**

Physican Signature: ____

Date: ____

If this form is not fully completed, this may delay patient care. Please always try to refer to us as soon as possible.