Perinatal Associates of Central California Medical Group, Inc Referral Form

Please Fax to 559-268-0650 When Completed **Phone 559-268-8307** **Office: □ North □ Downtown**

Complete for all

Patient's last name: ____________________ First name: ____________________ DOB: ____________
(As it appears on insurance or Medi-Cal card)
AGE:_____ LMP _________ EDC: _________ G _____ P _____ ☐ Not Pregnant **PACCMG Acct No** _________

Address:____ City: __________ Zip Code: _________

Phone ___________Work/Message Phone ____________ Language spoken: _____________ Pt has Interpreter ☐Y ☐N

Date: __________ **Completed By** ________________ **Appointment date/time** ____________________

Referring MD: ___________________________MD Address: _____________________________

City: ______________________ Zip: _______________ Phone: ____________________ Fax ____________________

Please include all appropriate records, as well as copy of insurance card, with this referral

Complete for all

INSURANCE INFORMATION (PLEASE INCLUDE COPY OF INSURANCE OR MEDI-CAL CARD)

Medi-Cal: ☐ Regular ☐ Health Net ☐ Blue Cross ☐ EHS ☐ La Salle ☐ Independence ☐ Presumptive

ID # ______________________________ Authorization (if needed) ______________________________

Other insurance: ____________________ ☐ HMO ☐ PPO Policy #:________________ Group # :____________

Authorization (if needed) ____________________Subscriber (if not pt) ____________________ DOB ________

Has patient had U/S performed? **Yes** **No** Date U/S done __________Gestational age by u/s on that date: ___________
☐ Twins ☐ Triplets

Complete for genetic pts only

Service Requested ☐ Gen counseling only ☐ Gen counseling, detailed u/s, and other testing if indicated
Please complete the following section for all genetic referrals

☐ AMA ☐ Abn 1st AFP ☐ Abn 2nd AFP ☐ Abn NIPS (Non-Invasive Prenatal Screening)
☐ Pregnancy history (be specific):______________________________
☐ FH of genetic condition, mental retardation or birth defects (be specific): ______________________
☐ Abnormal ultrasound (specify): ______________________________
☐ Exposures meds/drugs ____________________________ ☐ Other: ______________________

Complete for perinatal pts only

Ultrasound: indicate service requested and ***circle*** indication
☐ NT/First Screen + fetal & mat anatomy-uterus,ovaries ☐ First trim (bleed,no fht,hx ectopic,susp ectopic)
☐ NT/First Screen & serial u/s for (dm,LGA,htn,hx iugr,hx macro,hx sb,obesity,twin,trip)
☐ Serial ultrasound for (dm,LGA,htn,hx iugr,hx macro,hx sb,obesity,twin,trip)
☐ Cx length 1 time only (susp short cx,pos ffn) ☐ Cx length serial (hx ptb 18-26 wks,twin,trip,prev cerclage)
☐ Detailed (susp anomaly, hx anomaly)
☐ Complete (s<d, s>d, poor wt gain, low bmi, obesity) ☐ EFW 36+ weeks
☐ Fetal Echo for (dm,family history chd,poly,anomaly,obesity bmi>40,ivf ,mono di, arrhythmia,teratogen)
☐ Amnio for ____________ ☐ Perinatal Consultation ***(complete section below for indication)***

☐ Pregnancy history (be specific):______________________________
☐ Maternal Medical Condition (be specific): ______________________________
☐ Current Pregnancy Problem (be specific):______________________________
☐ Abnormal ultrasound (specify): ______________________________

For Office Use Only: Date Rcvd ________ By ________ Appt Ok'd by DH JLD JS ☐ By phone
Appt confirmed By _____ Date _______ with ________