Clinic Staff User Only:

Appt Date: _____

Appt Time: _____ (AM/PM)

OU Children's Physicians
PRENATAL DIAGNOSTIC CENTER

MR# ASSIGNED: _____
PT CALLED: Y____ N____
FAXED CLINIC: Y____ N____
CLINIC CALLED: Y____ N____
SCHEDULER: _____
DATE: _____

PHONE: (405) 271-5400 FAX: (405) 271-5696
1200 N. Phillips Ave (Children's Avenue) Suite 1A
Oklahoma City, OK 73104

REFERRAL SHEET

Patient Name: _____ Home / Cell: _____ DOB: _____
Patient Address: _____ LMP: ___/___/___ EDC: ___/___/___ BMI: _____
City, State, ZIP _____ Primary Language: _____ BLOOD TYPE: _____
Insurance Information:
(PLEASE ATTACH A COPY OF PATIENT'S INSURANCE CARD AND DRIVERS LICENSE TO THIS REFERRAL SHEET (FRONT & BACK)

INDICATIONS / DIAGNOSIS: _____
(PLEASE INCLUDE "ALL" PRENATAL RECORDS, LAB RESULTS, AND ANY PREVIOUS US RESULTS WITH THIS REFERRAL.)

MATERNAL HISTORY OF: _____

SCHEDULING INSTRUCTIONS: ☐ **PRIORITY** (24 - 48 HOURS) ☐ **URGENT** (explain): _____

OBSTETRIC ULTRASOUND: ** ☐ Singleton ☐ Multiples (# ___)

- ☐ First Trimester Viability
- ☐ First Trimester w/Nuchal Translucency
- ☐ Level I - Size and Dates (ultrasound ONLY no MFM consult)
- ☐ Level II (45 min MFM consult w/US)
- ☐ Follow-up/Growth (frequency: _____)
- ☐ Other: _____

(Perinatal consult if abnormality found on ultrasound)**

DIABETES SERVICES:

Type of Diabetes:

- ☐ Gestational
- ☐ Type 1
- ☐ Type 2
- ☐ Other: _____

Co-Management:

*** PLEASE NOTE ***

Patient will be seen for diabetes education **ONLY** if she is a transfer of care. Otherwise, patient will need to be referred to HAROLD HAMM DIABETES CENTER for diabetes education (405)271-3455.

ANTENATAL TESTING:

- ☐ BPP (specify frequency): _____)
- ☐ AFI (specify frequency): _____)
- ☐ NST (specify frequency): _____)

OBSTETRICAL SERVICES:

- ☐ Complete Transfer of Care
- ☐ New OB Visit
- ☐ Please sent updates on patient care

CONSULTS AND OTHER SERVICES:

- ☐ Consultation with Diagnostic Testing as Clinically Indicated (explain): _____
- ☐ Co-Management with Diagnostic Testing (explain): _____
- ☐ Maternal-Fetal Medicine Consultation (explain): _____
- ☐ Genetic Counseling (explain): _____

Referring Physician: _____
Contact Person: _____ Contact Phone: _____
Fax Number: _____ Date of Referral Request: _____

ATTENDING PHYSICIAN SIGNATURE / DATE: _____