MATERNAL FETAL MEDICINE – PERINATOLOGY

Request for Records / Patient Intake Form

(425) 899-2000
Fax: 899-2210

REFERRING PROVIDER – PLEASE FAX THE FOLLOWING RECORDS:

- ☐ MSAFP or triple screen report
- ☐ Current prenatal records
- ☐ Blood type and Rh status
- ☐ Full CBC results
- ☐ Previous ultrasound report (s)
- ☐ Reports from previous pregnancies
- ☐ Office registration face sheet
- ☐ Pertinent medical records
- ☐ Other ___________________________

Date: _______________ Patient name: ______________________________ Referred by: ____________________

Home #: __________________ Work #: ___________________ Employer: ______________________________

Patient address: ____

SS#: ____________________ DOB: ____________________ Prior patient at Evergreen Hospital? ☐ Yes ☐ No

Husband/Significant other: ____________________ Work #: ______________ Employer: ___________________

Reason for referral/Clinical information: ____

LMP: _______________ EDD: ___________________ # weeks at appointment: _________________________

Service requested:

- ☐ Genetic counseling
- ☐ OB Care
- ☐ RN Consult
- ☐ Ultrasound ☐ VCR
- ☐ Gestational Diabetic Counseling
- ☐ Amniocentesis
- ☐ MD Consult

Prior genetic counseling? ☐ Yes ☐ No

Where? ____________________________ Date: _____________________ Requested prior records: ☐

Insurance carrier: ____ Policy #: ______________________

Subscriber: ____________________ Group # : _______________________ Referral required? ☐ Yes ☐ No

Authorization # / Comments: ____

Genetic counseling appointment scheduled for: (date) ________________________________ Time: ____________

Appointment scheduled for (date): ______________________________________ Time: ____________________

☐ Dr. Robin de Regt ☐ Dr. Carolyn Kline ☐ Dr. Susan Rutherford ☐ Dr. Martin Walker

Records requested by phone: Date/time: ___________________________ Spoke with: _____________________

☐ Registered ☐ Sent for Insurance Verification ☐ Faxed this request to referring physician

Comments/Notes: