

MATERNAL FETAL MEDICINE UW MEDICAL CENTER

REFERRAL FAX: 206-598-2359 CLINIC PHONE: 206- 598-4070	Please ensure all OB and relevant medical, genetic records are in Care Everywhere or attached and faxed with this referral.
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Patient Name (Last Name, First Name, Middle Initial)		Date
Preferred Pronouns	Patient preferred language for healthcare communication	
Date of Birth	Patient Telephone	
Patient Home Address		
Patient Insurance Company and Plan(s)		

Referral From:

Referring Provider Name (Last Name, First Name, Middle initial)	NPI
Referring Provider Contact Telephone	Referring Provider Fax
Referring Provider Address	
Patient's Primary OB Provider (Last Name, First Name, Middle Initial)	

Reason for Referral:

EDD:	<input type="checkbox"/> Confirmed by Ultrasound	<input type="checkbox"/> By LMP
Gravida:	Para:	Referral: <input type="checkbox"/> Urgent <input type="checkbox"/> Routine
<input type="checkbox"/> Pregnancy Consult Reason/Diagnosis: _____		

<input type="checkbox"/> Pre-pregnancy Consult Reason/Diagnosis: _____		

<input type="checkbox"/> Transfer of OB Care	<input type="checkbox"/> Consult	
Consult may include Ultrasound, Genetic Counseling and Follow-up visits as clinically indicated.		

PROVIDER SIGNATURE	PRINT NAME AND TITLE	DATE	TIME
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PLACE PATIENT LABEL HERE

UW Medicine
MATERNAL FETAL MEDICINE REFERRAL REQUEST
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