MUNSON HEALTHCARE

Form 12462 (11/21)

FETAL ECHOCARDIOGRAM REFERRAL

12462

Patient Demographics	Referring Physician
Patient's Legal Last Name:	Physician (print name):
First Name:	Referring office phone number:
Middle Name:	Referring office fax number:
Date of Birth: _____ /_____ /_____	Date Ordered:
Address:_____	(Office Stamp here)
Phone Number:	
Alternate Phone Number:	
Pregnancy Details:	**Services Requested:**
LMP:	☐ Fetal Echocardiogram (ideal timing 22-24 weeks gestation)
EDC:	
Gravida: Para:	
Current G.A. _____ weeks	

Referral Indication/Diagnosis:_____

_____

Associated ICD-10 Codes: _____

Scheduling Requests:

☐ No preference/First available (with appropriate timing for fetal echo)

☐ Scott Maurer, MD (Michigan Medicine/University of Michigan)

☐ Jeffrey Schneider, MD (Spectrum Health/Helen Devos Children's Hospital)

_____ _____ _____

Referring Physician Signature **Date** **Time**

Please send referral to:

Maternal Fetal Medicine (Traverse City Clinic)
Fax: 231-935-2127
Phone: 231-392-8280

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PATIENT ID LABEL