Yale NewHaven **Health**

Yale New Haven Children's Hospital

Fetal Care Center Referral

1 Long Wharf Drive, 2nd floor
Phone: 203-688-6018, 203-688-2800 – Fax: 203-688-2806

Circle One: New Return Appointment Date:_________ Time:______

Patient Name: ____

Address: ____

DOB: ____________________ YNHH MR#: ________________________

Home phone: _____________ Cell: _____________ Work: _______________

Insurance: ____

Patient Information: G_____ P_____ T____ P____ SAB____ TAB____ Ectopic _____ LC____

LMP: ____________ EDD: _____________ Based on: ☐ LMP ☐ US ☐ Other:______

Blood Type: _____ Height: _____ Weight: ______ Earliest US: Date ___/___/___= _______ weeks

Allergies: _________________________________ Interpreter? ________________

Referral for: (ultrasound type)
- ☐ Suspected Fetal Anomaly (Level II anatomy)
- ☐ Known Fetal Anomaly (Level II anatomy and Fetal Echo)
- ☐ Twin to Twin Transfusion Syndrome (Level II anatomy)
- ☐ Fetal Procedure (gestational age dependent)

Pregnancy Type:
- ☐ Singleton
- ☐ Twins
- ☐ Triplets

☐ **Ultrasound consultation and MFM US Management for the remainder of the pregnancy**
☐ **Prenatal Genetics Consult with plan for:** ☐ **CVS** ☐ **Amniocentesis**

Reason for referral and pertinent medical/surgical/prenatal history:

Please fax the following with this referral (if not performed through Yale New Haven Hospital):
- ☐ All 1st and 2nd trimester maternal serum screening results
- ☐ All prior ultrasound reports
- ☐ All prior genetic carrier screening (CBC/Hgb electrophoresis), CF, SMA, Fragile X, etc.
- ☐ **If the patient is having a CVS/amniocentesis procedure, original lab reports for blood type/screen, HIV status, + gonorrhea/chlamydia cultures (CVS only) from current pregnancy must be provided.**

Referring Provider: Date: _______________
Name: _________________________________ Phone:_____________
Address: ______________________________ Fax: ______________
****PROVIDER SIGNATURE**** ____

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