For Office Use Only

Appt Date: ______

Appt Time: ______ AM/PM

Valley Perinatal™

John Elliott, MD
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Hugh Miller, MD
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Kathleen Kuhlman, MD
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Valerie Infranco, WHNP
Francisca Fletes, WHNP
Susan Roberts, WHNP
Sue Ellen Sarsam, WHNP

Referral Sheet

To schedule an appointment, phone, fax, or use our secure Website

Phone: 480.756.6000 Fax: 480.467.2165 www.valleyperinatal.com

Patient Name: ______________________________ DOB: ____________________

Contact Number: ______________________________ EDC: ____________________

Insurance: ____________________ Group #: ______________ ID #: ______________

SCHEDULING INSTRUCTIONS: ❑ Schedule **STAT** ❑ Schedule **PRIORITY** (24 – 48 HOURS)

❑ Call patient to schedule ❑ Patient will call ❑ Call Report **STAT**

INDICATIONS/DIAGNOSIS : ____

OBSTETRIC ULTRASOUND** ❑ Singleton ❑ Multiples (#____)

- ❑ First Trimester Viability
- ❑ First Trimester w/Nuchal Translucency
- ❑ Fetal Anatomy
- ❑ Follow-up/Growth (frequency: ____________)
- ❑ Fetal Echocardiogram
- ❑ Fetal Dopplers: ❑ Umbilical ❑ MCA
- ❑ Uterine Artery Doppler (Maternal)
- ❑ Other: ____________

****Perinatal consult if abnormality found on ultrasound**

ANTENATAL TESTING

- ❑ BPP (frequency: ____________)
- ❑ AFI (frequency: ____________)
- ❑ NST (frequency: ____________)

PROCEDURES

- ❑ CVS (includes genetic counseling)
- ❑ Amniocentesis (includes genetic counseling)

GYNECOLOGIC ULTRASOUND

- ❑ Pelvic Ultrasound
- ❑ Sonohysterography
- ❑ Other ____________________

BLOOD TESTS

- ❑ NIPT (Cell Free Fetal DNA)
- ❑ Other: ____________________

FOLLOW-UP TESTING

(as recommended/ordered by VPS)

❑ Ultrasound ❑ Antenatal Testing

CONSULTS AND OTHER SERVICES

- ❑ Maternal-fetal medicine consultation (reason): ______________________________
- ❑ Co-management high risk condition (reason): ______________________________
- ❑ Genetic counseling (reason): ❑ Abnormal Screen ❑ AMA ❑ Preconception Consult ❑ Family History
- ❑ Nutritional Counseling (celiac disease, obesity, any other non-diabetic)

DIABETES SERVICES

TYPE of Diabetes: ❑ Gestational ❑ Type I ❑ Type II ❑Other: ____________________

- ❑ **Consultation Only**: 30 min perinatal w/US, 90 min visit w/Registered Dietician, NP follow-up visit
- ❑ **Consultation w/Co-Management**: Consultation (as listed above) and ongoing diabetes co-management

Referring Physician: ______________________ Date of Request: ____________________

Phone: ______________________________ Fax: ______________________________

WE KINDLY REQUEST THAT YOU SEND ALL PERTINENT MEDICAL RECORDS

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