HIGH RISK PREGNANCY CENTER OF ARIZONA
Krunal Patel, MD

REQUEST FOR MATERNAL-FETAL MEDICINE SERVICES

Phone: 602-767-5636 **Fax: 833-595-2429**

For STAT consultation please call our office or physician directly after faxing this form.

Today's Date: _____

PATIENT AND REQUESTING INFORMATION: ALL FIELDS ARE REQUIRED. INCOMPLETE FORMS WILL DELAY SCHEDULING.
Please fax all prenatal records including genetic screening, ultrasound lab results with request form.

Patient Name:	DOB:
EDD:	Cell #
Requesting provider:	Requesting practice:
Phone#	Fax #
Requesting provider Signature:	
☐ Routine (1-4 weeks) ☐ Urgent (within a week) ☐ STAT (1-2 days)	

Indication/Diagnosis:

☐Diabetes
☐Multiple gestation
☐Size-date discrepancy
☐Preconception counseling
☐Other indication _____

☐AMA
☐Obesity
☐HTN
☐IVF/REI

☐Ultrasound screen for anomalies
☐Abnormal screen (1st or 2nd trimester, NIPT)
☐Suspected placenta accrete
☐Family Hx of _____
☐Fetal anomaly _____

Request for Ultrasound/Procedure

MFM to schedule follow-up as clinically indicated? ☐ Yes ☐ No

☐ Detail Anatomy
☐ Follow up OB scan
☐ Fetal Echocardiogram
☐ NT scan
☐ BPP
☐ NST

☐ Complete OB scan
☐ Cervical Length
☐ Viability
☐ First trimester anatomy
☐ Fetal Doppler evaluation

Multiple Gestation:(check one)

☐ Twin ☐ Triplet ☐ Higher order
☐ Amniocentesis

Placenta:(check one)

☐ Previa ☐ Abruption ☐ Placenta accreta
☐ Other _____

Request for consultation

☐ MFM consult: ☐ Co-Management ☐ Transfer of care
Indication_____
☐ Preconception consult: _____
☐ Diabetes education and Management (includes MFM consultation)

By submission of this request, the referring provider authorizes Maternal Fetal Medicine consultation in the event of unanticipated findings unless otherwise directed.

Address: 9250 N. 3rd Street, Suite # 2007 Phoenix, AZ 85020