MUNSON HEALTHCARE

Form # 11808 (05/18)

FETAL TESTING REQUEST PHYSICIAN'S ORDERS

11808

Patient Information

Patient's Legal Last Name:	First Name:	Middle:
Date of Birth: _____/_____/_____ Date Ordered: _____/_____/_____	LMP: EDC:	Current G.A. _____ weeks
Home Phone: ( ) - _____ - _____	Other Phone: ( ) - _____ - _____	
Address:	City:	State: Zip Code:
Insurance:	Referring Physician (print name):	
Physician Signature:	Date and Time Signed:	

Indications/Diagnosis for Consultation and Ultrasound - Please include all pertinent information:

☒ **MFM PHYSICIAN CONSULTATION AND ULTRASOUND**		**TEST(S) REQUESTED: PLEASE CHECK ALL THAT APPLY**	
	Fetal Non Stress Test, BPP / Dopplers, TV		**Ultrasounds:**
	NST 1X Only		Detailed **19-20 wks** Anatomy - 1st Detailed Ultrasound performed by MFM; Transvaginal to check cervix as needed
	NST 1X week and BPP/Dopp 1X week - Standing		
	NST 2X week and BPP/Dopp 1X week - Standing		< 14 weeks Semi Complete Ultrasound, (dating, viability); Transvaginal to check cervix as needed
	Biophysical Profile, Dopplers, w/NST 1X		
	Biophysical Profile, Dopplers, w/out NST 1X		< 14 weeks Ultrasound, Nuchal Measurement, Integrated Screen; TV to check cervix as needed
	Fetal Echocardiogram (approx. 22 weeks)		
	Repeat/Follow-up Fetal Echocardiogram		> 14 weeks Ultrasound (14-18 weeks, dating, IUFD); Transvaginal to check cervix as needed
	Amniocentesis - Ultrasound Guided		
	Transvaginal and Limited (Cervical length, viability) 1X		Follow-up Ultrasound 1X for growth, **after Detailed**
	Transvaginal and Limited, Cervical length every _____ wks		Follow-up Every 3-4 weeks - Standing order
	Limited Ultrasound (Specific Test: i.e., placenta check)		Follow up as recommended by MFM Clinic: AFI Doppler, Fetal Growth, Fetal Echo, MCA Dopplers, Biophysical Profile (BPP), Cervical length, Non-Stress Test (NST)

DIAGNOSIS: PLEASE CHECK ALL THAT APPLY

	Abn. AFP / Quad, Chromo		Fetal Damage Drug		Polyhydramnios (☐ Fluid)		Twins
	Abn. Cervix Other		Fetal Demise > 22 weeks		Poor Fetal Growth		**High Risk Preg/Supervision of**
	Abn. Fetal Heart Rate		Habitual Aborter		Post Term		High Risk Preg/IVF
	Adv. Maternal Age-MULTI		Hemorrhage-unspecified		Pre-eclampsia Mild		High Risk Preg/Insufficient care
	Adv. Maternal Age-PRIMI		Hypertension Essential		Premature Rupture Membrane		High Risk Preg/Poor OB Hx
	Cervical Incompetence		Hypertension Transient		Premature Separation Placenta		Other Known/Suspected Fet Abn
	Decreased Fetal Movement		Isoimmunization		SUA-2 Vessel Cord		UNSPECIFIED Fetal Abnormality
	Diabetes-EXISTING		Missed AB, Blight Ovum		Threatened AB		SCREENING F/MALFORMATION
	Diabetes-GESTATIONAL		Obesity		Threat / Pre Term Labor		Other:
	Discrepancy Size/Dates		Oligohydramnios		Thrombophilia		
	Drug Dependency		Placenta Previa		Thyroid Dysfunction		
	Excess Fetal Growth		Placenta Previa w/Hem		Triplets		

Was 1st Trimester Ultrasound done?	Yes	No	☐ **GENETIC COUNSELOR**	
If performed already, include results			Was Cell Free DNA or Aneuploidy Screening done?	Yes / No
Was Detailed Ultrasound Done Elsewhere?	**Yes**	**No**	Pending (please indicate with 'X')	
If YES, *Include Ultrasound Report*			Normal	
☐ **DIABETES EDUCATION**			Abnormal	
Was HbA1C done?	Yes	No	If performed already, include results	
Was 1 hour GTT done?	Yes	No		
Was 3 hour GTT done?	Yes	No		
If performed already, include results				

PATIENT ID LABEL HERE

To refer a patient to the Maternal Fetal Medicine Clinic, please fax this form and these required documents: Patient demographics, prenatals (including gravida/parity), labs, ultrasounds and any pertinent medical history or consults to **231-935-2127.**

Select a location: ☐ Traverse City Clinic ☐ Manistee Clinic