SAINT FRANCIS Hospital and Medical Center

Mount Sinai Rehabilitation Hospital
a SAINT FRANCIS *Care* Provider

Patient Label

# OBGYN MFM Consult & Procedure Form


Fetal Assessment Center (NST) 860-714-6591
Obstetrical Ultrasound 860-714-1323
Gynecological Ultrasound 860-714-6591

114 Woodland Streeet
Hartford, Connecticut 06105-1299
FAX 860-714-8073


GRANTED ACCREDITATION AIUM 2012-2015

Patient's Name _____

D.O.B. ____ /____ /_____ Last 4 Digits of S.S.#_____

Telephone #s (H) _____ (W) _____ (C) _____

*Please circle best number & note if OK to leave a DETAILED message*

Address _____ City _____ State _____ Zip _____

**Clinical Information** **Please fax serum screen(s); previous ultrasounds**

LMP: ___ /____ /____ EDC:___ /____ /____ Ultrasound on:___ /____ /____ USEDC:____ /____ /____

Final EDC: _____ /____ /____

Gravida: _____ Parity: _____ AB: _____ Spontaneous AB: _____ Living Children: _____

Weight: _____ Height:_____ RH _____ (+/-) ____

**Reason for referral:** _____

**Does your patient have insurance?** ☐ **No** ☐ **Yes** **Please fax copy of Current Insurance card to 860-714-8073**

**Provider's Responsibility to obtain Authorization 30-40 days prior to date of service (DOS). Please return to US 72 hours prior to DOS.**

**Preauthorization:** Pending Obtained Not Required Spoke to:_____ Date: ____ /____ /____

**Preauthorization Number:** _____ **Reference Number:** _____ **Date range:**___ /___ /____

**First Trimester Testing** (select one)

☐ Nuchal Translucency Screening (11-13 weeks)
**With Consult & Diagnostic testing when clinically indicated**
**Please Fax Serum Prescription
CPT: 76813; 76801

☐ Chorionic Villus Sampling
CPT: 53920; 76801

**Second/Third Trimester Testing** (select all that apply)

☐ Obstetrical Ultrasound or Detailed Ultrasound /Cervical screening
**With Consult & Diagnostic testing when clinically indicated**
CPT: 76805 / 76811 / 76817

☐ Cervical Length as indicated; CPT: 76817
**With Consult & Diagnostic testing when clinically indicated**

☐ Genetic Amniocentesis
CPT: 59000; 76811

☐ Amniocentesis for Fetal Lung Maturity
CPT: 59000; 76816

☐ Antepartum Fetal Testing (NST/ Biophysical Profile/ AFI as indicated) CPT: 59025; 76815; 76818

☐ Genetic Consult Please fax over medical and obstetrical history, labs and previous consults.

☐ MFM Consult Please fax over medical and obstetrical history, labs and previous consults.

**Physician Signature** _____ **Date:** ____ /____ /____ **Time:** _____

**Office** to which report should be sent: _____

Provider's Preference: **SAME DAY** **ASAP - This week** **1-2 Weeks** **2-4 Weeks** **4-6 Weeks**

---

****Please allow 48-72 hours for a response to your Request****

**This sheet or an Itinerary will be faxed to the office you indicated above, with your patient's appointment time.**

****Please call 860-714-1323 with any questions or if your patient is unable to make this date and/or time.****

Patient's preference for DATE and TIME: _____

---

****For Ultrasound Department Use only****

**Above Patient scheduled for Date:** _____ /_____ /_____ **Time:** _____ AM PM