**TENNESSEE MATERNAL FETAL MEDICINE, PLC**

**300 20TH Avenue North, Suite 702, Nashville, TN 37203**

**1800 Medical Center Pkwy, DePaul Blg. Ste 320 Murfreesboro, TN 37129**

**100 Covey Dr, Suite 207, Franklin, TN 37067**

**(615) 284-8636 Fax (615) 284-8637**

**CONSULTATION & DIAGNOSTIC TESTING REQUEST**

**LOCATION: □ NASHVILLE (M-F) □ MURFREESBORO (M- Th) □ FRANKLIN (M- Th)**

**APPOINTMENT DATE: \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ TIME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ AM PM**

**PATIENT DEMOGRAPHIC DATA:**

**ESTIMATED DATE CONFIRMATION: \_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_ G\_\_\_\_\_\_\_\_ P\_\_\_\_\_\_\_\_**

Pt’s Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M: \_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Phone Number: (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/ST/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE INFO:** \*Please attach copy of insurance card\*

**CONSULTATION REQUEST:**

**□ With Diagnostic Testing, as clinically indicated □ One-time Consult, with Diagnostic Testing, as clinically**

 **& subsequent Co-Management indicated**

**□ ULTRASOUND ONLY** (**with additional diagnostic testing**

 **as clinically indicated)**

**PROVIDER NAME (printed):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PROVIDER SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DIAGNOSTIC TESTING REQUEST *-* PLEASE CHECK DIAGNOSTIC TEST ORDERED**

□ Anomaly Screening (18-20 WEEKS) □ GYN Ultrasound Transabdominal & Transvaginal

□ < 14 Weeks Scan □ Postpartum Diabetes Management (E&M Visit)

□ > 14 Weeks Scan □ Diabetes Management (E&M Visit)

□Follow Up Ultrasound □ Coumadin Management

□Biophysical Profile (BPP) □ Doppler Flow Study

□ Cervical Length □ NT Lab Draw between 9-13 Weeks for IRA

□Amniocentesis □ Nuchal Translucency Screening W/Consult

□ Chorionic Villus Sampling (CVS) □ Dx - Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT BLOOD TYPE:** \_\_\_\_\_\_\_\_\_\_\_\_

**DIAGNOSIS/REASON FOR REFERRAL:**

**\* *CMS Program Memorandum AB-01-144 Change Request -******Effective January 1, 2002 referring diagnosis is required for diagnostic testing. Suspected or rule-out statements are NOT applicable, if no confirmed diagnosis, PLEASE list symptoms.***

□ Known/Suspected Fetal Abnormality

□ Advanced Maternal Age

□ Cervical Incompetence

□ Multiple Gestations \_\_\_\_#

□ Prior Fetal Loss

□ Early/Threatened Labor

□ Large for Dates

□ Small for Dates

□ CHTN

□ Thrombophilia

□ Polyhydramnios

□ Oligohydramnios

□ Congenital Disorder

□ Endocrinologic Disease

□ Hematologic Disease

□ Infectious Disease

□ Drug Exposure

□ Diabetes Mellitus I or II

□ GDM

□ Gastrointestinal Disease

□ Neurological

□ Renal Disease

□ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please sign and fax with any pertinent clinical information to 615-284-8637. Thank you!**

**\*For TMFM Use Only, Please\***

***Verbal Order Taken by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ From: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***