

# Maternal-Fetal Medicine Referral Form

## COMMUNITY HEALTH NETWORK

### MAIN LOCATION

**Hours: Mon-Fri 8-5**

7120 Clearvista Drive  
Suite 5900  
Indianapolis, IN 46256

### SOUTH LOCATION

**Hours: Wed 1-5 Thursday 8-5**

1550 East County Line Road S.  
Suite 301  
Greenwood, Indiana 46227

*Appointments can be scheduled for all offices by:*

**Faxing referral form to (317) 621-9211**

**or calling (317) 621-9210**

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Referring Date: \_\_\_\_\_

Medical Record # \_\_\_\_\_

Appointment Date: \_\_\_\_\_ Appointment Time: \_\_\_\_\_ Wks Gest. \_\_\_\_\_

EDC: \_\_\_\_\_ by LMP or U/S: \_\_\_\_\_ \*\*Blood Type: \_\_\_\_\_ Appointment With: \_\_\_\_\_

*Due to CMS Program Memorandum A8-01-144 Change Request 1724 dated September 26, 2001 effective January 1, 2002 referring diagnosis is required for a diagnostic testing. Suspected or rule-out statements are not applicable, if no confirmed diagnosis, please list symptoms*

Diagnosis/Reason for Appt: \_\_\_\_\_

<input type="checkbox"/> Consultation Only	<input type="checkbox"/> Non-stress testing	<input type="checkbox"/> Ultrasound only
<input type="checkbox"/> Consultation with ultrasound, if applicable	<input type="checkbox"/> Biophysical profile	<input type="checkbox"/> Ultrasound with consult, if applicable
<input type="checkbox"/> 2nd opinion Consultation	<input type="checkbox"/> Amniocentesis	<input type="checkbox"/> Total Assume Care
<input type="checkbox"/> Genetic Counseling	<input type="checkbox"/> Chorionic villus sampling	<input type="checkbox"/> Fetal Echo
<input type="checkbox"/> Advanced Maternal Age	<input type="checkbox"/> First Trimester Screening	<input type="checkbox"/> Urology Consult
<input type="checkbox"/> Other, please specify _____		

Comments: \_\_\_\_\_

## PATIENT INFORMATION

Patient Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_  
DOB: \_\_\_\_\_ SSN \_\_\_\_\_ Race: \_\_\_\_\_ Marital Status: (M) \_\_\_\_\_ (S) \_\_\_\_\_ (D) \_\_\_\_\_ (W) \_\_\_\_\_ (O) \_\_\_\_\_  
Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone: ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_ Cell ( ) \_\_\_\_\_ Other ( ) \_\_\_\_\_  
Employment: \_\_\_\_\_ Address: \_\_\_\_\_  
Family Physician: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_  
Emergency contact: \_\_\_\_\_ Relationship to Patient \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

## SPOUSE / OTHER INFORMATION

Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone: ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_ Cell ( ) \_\_\_\_\_ Other ( ) \_\_\_\_\_  
Employment: \_\_\_\_\_ Address: \_\_\_\_\_

(continued on other side)

**REFERRING PHYSICIAN INFORMATION**

Person requesting referral appointment: \_\_\_\_\_

Physician Name: \_\_\_\_\_

Physician Group Name: \_\_\_\_\_

Phone #: (\_\_\_\_) \_\_\_\_\_ Fax #: (\_\_\_\_) \_\_\_\_\_

UPIN #: \_\_\_\_\_ Medicaid #: \_\_\_\_\_

Address: \_\_\_\_\_

**INSURANCE INFORMATION**

**PRIMARY:** \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

ID# \_\_\_\_\_ Group# \_\_\_\_\_ Group Name: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

DOB: \_\_\_\_\_ SSN: \_\_\_\_\_ Authorization # \_\_\_\_\_

**SECONDARY:** \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

ID# \_\_\_\_\_ Group# \_\_\_\_\_ Group Name: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

DOB: \_\_\_\_\_ SSN: \_\_\_\_\_ Authorization # \_\_\_\_\_

Person completing form: \_\_\_\_\_

Entered in computer \_\_\_\_\_ Packet mailed \_\_\_\_\_ Appt. confirmed: \_\_\_\_\_