REFERRAL

You have been referred to Diablo Valley Perinatal Associates. We look forward to meeting you at your visit. In order to make your time with us more efficient, we encourage you to visit out web site (www.diablovalleyperinatal.com) where you will find helpful information about our practice, your pregnancy, practice policies, directions to our office and registration forms you can complete prior to your visit.

PLEASE BRING THIS REFERRAL FORM TO YOUR APPPOINTMENT OR HAVE IT FAXED TO OUR OFFICE.

Patient Name_____ DOB ___/___/___ LMP/EDC___/___/___

ULTRASOUND

- ◯ Early Ultrasound *(viability, dating, NT, threatened Ab, ectopic pregnancy, etc)*
- ◯ Comprehensive Anatomic Survey *(generally 20-21 weeks)*
- ◯ Follow Up/Growth Ultrasound *(twins, size/date, decreased FM, HTN, DM, fibroids, SLE, etc)*
- ◯ Cervical Length
- ◯ Second Opinion For Ultrasound Done at Another Facility
- ◯ Other, please specify_____

_____

PERINATAL SERVICE

- ◯ Consultation
- ◯ Co-management/transfer care
  Reason _____

ANTENATAL TESTING

- ◯ NST/BPP/AFI
  Reason _____

PRENATAL DIAGNOSIS/SCREENING/COUNSELING

- ◯ Amniocentesis/CVS
- ◯ Genetic Counseling

Blood type _____ Antibody screen _____

Please fax all prenatal records and previous ultrasounds for any consultation with a Perinatologist. Please provide Blood type and Rh for anyone undergoing an amniocentesis or CVS, reports for any previous ultrasounds done at another facility and any relevant lab results for genetic counseling appointments.

Perinatal consultation/diagnostic testing/follow-up ultrasound are requested for any fetal/maternal medically indicated condition known/identified.

Physician signature (*required*)_____ Date _____

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