***MATERNAL-FETAL MEDICINE CONSULTATION***

**Referring Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_\_\_**

**SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

**Contact #1:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Contact #2:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Primary Insurance:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ID#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Subscriber: YES NO: Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Secondary Insurance:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ID#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Seen Before: Yes/Year\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NO**

**EDD/ Weeks gestation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Referring Diagnosis:**

* **Abnormal Screening for:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Abnormal Ultrasound:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **AMA**
* **Anatomy Scan**
* **Diabetes: Pre-Gestational or Gestational**
* **Epilepsy**
* **Fibroids**
* **History of previous pregnancy:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Hypertension: Chronic or Pregnancy Induced**
* **IVF Pregnancy**
* **MTHFR/Thrombophilia/Anti-Phospholipid syndrome**
* **Multiple gestation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Previous Preterm Delivery**
* **Threatened Preterm Labor**
* **Shortened Cervix/Cervical Insufficiency**
* **Vaginal Bleeding**
* **Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***Please include Prenatal Record, All labs and Ultrasound***

**Dear Doctor:**

**My goal is to partner with your office to provide the best in high risk obstetric care!**

**My office is open Mondays through Thursdays, from 8:00 AM through 5:00 PM, and half days on Fridays, 8:00 AM until 12 noon.**

**We have same-day urgent availability, and can usually see non-urgent referrals within 2 to 3 days.**

**Thank you for trusting us with your high risk pregnancies!**

**You can call or text me at any time on my cell phone, 706-513-3032.**

**For you convenience, I am enclosing referral forms.**

**Please fill out the referral form and fax to: 706-722-7337, or e-mail to**

**jdavis@janetdavismd.com**

**Thank you for your referrals!**

 **Thanks again,**

 **Janet E. Davis, MD, FACOG**

 **Maternal Fetal Medicine**