UCSF Health
Women's Health

PHONE (415) 353-3400 **FAX** (415) 353-4077

☐ **San Francisco:** 1825 Fourth St., Floor 3B | San Francisco, CA 94158
☐ **Berkeley Outpatient Center:** 3100 San Pablo Ave. | Berkeley, CA 94702
☐ **Marin/Greenbrae:** 1300 S. Eliseo Dr., Suite 200 | Greenbrae, CA 94904
☐ **Monterey:** 2 Upper Ragsdale Dr., Bldg. B, Suite B100 | Monterey, CA 93940
☐ **San Mateo:** 1100 Park Place, Suite 100 | San Mateo, CA 94403

UCSF Prenatal Diagnostic Center Referral Form

REQUIRED PATIENT INFORMATION

The following is required to be faxed: *Facesheet with complete patient demographics, this form, prenatal records and a clear copy of the patient's insurance card.*

Patient Name: DOB: Age: BMI:

Address: City: State: ZIP:

Phone: **Interpreter Needed:** ☐ YES ☐ NO If yes, language:

Insurance Type: ☐ HMO ☐ PPO ☐ POS ☐ Other:

REASON FOR VISIT (required)

Indication(s): ICD-10:

EDD/EDC: _____ or LMP: _____ ☐ Singleton ☐ Twins ☐ Triplets ☐ Other:

REQUESTED APPOINTMENT TYPE (consultation/follow-up may be scheduled as clinically indicated)

Please check all that apply *and include required documents for specific visit types. Note: All ultrasounds include MFM discussion of findings.*

☐ **Nuchal Translucency Ultrasound (includes First Trimester Anatomy; all sites)**
If the patient had Cell-Free DNA (NIPT) Screening, please fax a copy of the results.
If NIPT is pending, include D# _____

☐ **First Trimester Detailed Anatomy (Mission Bay Specialty Clinic for High-Risk Patients)**
Required: *All relevant obstetric ultrasounds, genetic testing results and history reports.*

☐ **Second Trimester/Level II Anatomy Ultrasound**
Please fax a copy of patient's CA Second Trimester (AFP) Screening and Cell-Free DNA (NIPT) test results prior to the patient's visit.
If CA Second Trimester (AFP) screening is pending, include S# _____

☐ **CVS (Chorionic Villus Sampling)**
Required: *Hard copy of lab work, including MCV, blood type and antibody screen.*
If the patient had Cell-Free DNA (NIPT) Screening, please fax a copy of the results.

☐ **Amniocentesis**
Required: *Hard copy of lab work, including MCV, blood type and antibody screen.*
If the patient had Cell-Free DNA (NIPT) Screening, please fax a copy of the results.

☐ **Positive PNS (CA Prenatal Screening Program)**
Required: *Hard copy of lab work, including MCV, blood type, antibody screen, prenatal records and other screening results (AFP, NIPT, Carrier Screen).*

☐ **Genetic Counseling**
Prior to visit, send: *Prenatal records, screening results (AFP, NIPT, Carrier Screen) and other relevant genetic testing results.*

☐ **Fetal Echo** (supported by fetal cardiovascular program)
Required: *Fax form to ucsfbenioffchildrens.org/fetalechorequest*

☐ **Second Opinion Scan or Concern for Anomaly**
Required: *All relevant obstetric ultrasounds, genetic testing results and history reports.*

☐ **MFM Consultation** *(Please indicate reason(s) below)*
☐ Ultrasound Finding or ☐ Maternal Condition
Required: *All relevant obstetric ultrasounds, genetic testing results, prenatal records and history reports.*
Consult question requested: _____

☐ **Maternal Genetics Consultation (Specialty Clinic for Patients with Genetic Conditions)**
Required: *All relevant obstetric ultrasounds, genetic testing results and history reports.*

☐ **Other:** _____

Please check with insurance carrier *for patient coverage and benefits and provide us with a copy of the Authorization for HMO Insurances.*

PROVIDER OFFICE INFORMATION

Referring Provider Name:

Address: City: State: ZIP:

Phone: Fax: Date:

Made accessible 1/25

10.2024-WF331111