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: