Florida Perinatal Center LLC

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APPOINTMENT REQUEST FORM

Please fax form and all other scheduling correspondence/records to (954) 255-1989.

Date: _____

Referring Physician: _____ Contact Person:_____

Office Address: _____ _____

Phone: _____ Fax: _____ Backline: _____

Patient Name (Please Print): _____

Social Security # : _____ DOB: _____ Age: _____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Work Phone: _____ Mobile: _____

E-Mail Address: _____

Insurance Company : _____ PO Box: _____ City: _____ State: ___ Zip: _____

Policy #: _____ Group #: _____ Phone # : _____

Insured Name: _____ Relationship to Patient: _____ □ HMO □ PPO □ POS □ OTHER

LMP: _____ EDC: _____G____P____A____L____ LOCATION: CORAL SPRINGS _____BOCA RATON_____

Preferred day of the week/time for the appointment_____

INDICATION/DIAGNOSIS:

- ☐ Abnormal genetic screen
- ☐ AMA
- ☐ Decreased fetal movement
- ☐ Diabetes
  - ☐ Gestational
  - ☐ Pre-gestational
- ☐ Fetal abnormality: _____ _____
- ☐ Habitual Abortion
- ☐ Hypertension
- ☐ HX of fetal demise
- ☐ Incompetent cervix
- ☐ IVF
- ☐ Hypothyroid
- ☐ Hyperthyroid
- ☐ HX of genetic disorders: _____ _____
- ☐ Size unequal to dates
- ☐ Medication or drug exposure
- ☐ Multiples Gestation
- ☐ Obesity
- ☐ Oligohydramnios
- ☐ Placenta Previa
- ☐ Polyhydramnios
- ☐ Pre-eclampsia
- ☐ Other: _____

SERVICES REQUIRED:

- ☐ Consultation Only
- ☐ Consultation with sono as indicated
- ☐ Diabetic Consult
- ☐ Genetic Consult

FETAL EVALUATION:

- ☐ Integ/Seq screen only
- ☐ Integ/Seq screen with 1st trimester sono
- ☐ 1st trimester sono
- ☐ NT Only
- ☐ Anatomy/Level II
- ☐ 34 Week / Growth Scan
- ☐ CVS
- ☐ Amniocentesis
- ☐ Transvaginal
- ☐ BPP/NST
- ☐ BPP Only
- ☐ Fetal Echo
- ☐ NIPT (Non-invasive pre-natal test)
- ☐ Other: _____