



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: _____

Office Address: _____

Phone: _____ Fax: _____ Backline: _____

Patient Name: _____ DOB: _____

Address: _____ Apt: _____

City/State/Zip: _____ Phone#: _____

E-Mail Address: _____

Insurance: _____ Policy ID#: _____

Ins Address: _____ Grp: _____ Phone#: _____

Insured Name: _____ Relationship to Patient: _____

Notes: _____

LMP: _____ EDC: _____ G _____ P _____ A _____ L _____

Step 1: SERVICES REQUIRED:

- Consultation w/Sono as Indicated Consultation Only No Consultation
 Genetic Consultation Diabetic Consultation

Step 2: FETAL EVALUATION:

- Co-Manage Pregnancy
- 1st Trimester Ultrasound & Nuchal Translucency (NT)
- 1st Trimester Ultrasound
- Nuchal Translucency
- NIPT
- Anatomy Scan (Level II)
- Growth Scan _____ wks
- Transvaginal Ultrasound
- BPP / NST
- BPP Only
- Fetal Echo
- CVS Indication: _____
- Amniocentesis Indication: _____
- Other: _____

Step 3: INDICATION / DIAGNOSIS:

- Abnormal Genetic Screening IVF
- Abnormal Carrier Screening Hypothyroid
- MOB _____ Hyperthyroid
- FOB _____ HX of Genetic Disorders (list)
- Advanced Maternal Age (AMA) HX of Preterm Labor / Delivery
- Decreased Fetal Movement Medication/Drug Exposure (list)
- Diabetes Type (Indicate below) Multiple Gestation
 - Gestational Pre-Gestational Oligohydramnios
 - Type I Type II Placenta Previa / Accreta
- Fetal Abnormality: _____ Polyhydramnios
- Habitual Abortion Pre-Eclampsia
- Hypertension Size Unequal to Dates
- HX of Fetal Demise Other: _____
- Incompetent Cervix