New Patient Referral Request to BCH AFCC

Please fill out **ALL** fields and fax to (617) 730-0124

For all questions please call the Advanced Fetal Care Center at (617) 355-6512

Patient Information:

Full Name: ______________________________ Maiden Name__________________________________ DOB: _________________

Home Address: ____ City: ____________________ State: _______ Zip: ____________

Phone Number: (___) ______________ Email_________________________________ Interpreter (Y/N) ___________

Cell Phone: (___) ______________

Indication/Diagnosis____

Other specialist's patient has seen during current pregnancy ______________________ Prior pregnancy/child care at BCH _____

EDC _____________________ **Singleton**_____ **Twins** _____ Other _____ PCP: ____

(Required for insurance purposes)

Current anticipated delivery location ________________________________

Insurance Company: _______________________ Plan Name: ___________________Insurance ID Number: _________________

***** When sending referrals please ensure that patient has insurance that is accepted by Boston Children's Hospital (BCH). If you have any questions please contact BCH's patient financial services at 617-355- 3397*****

Referring Physician Information:

Physician Name: __________________________________ Physician Specialty: ☐OB ☐MFM ☐Cardiologist ☐Other

Practice Name: ______________________________________ Physician Email ____

Physician Phone Number: (___) ______________ Practice Fax Number: (___) __________________________

Address: _____________________________________ City: ____________________ State: _______ Zip: __________________

Primary OB (if Different): __________________________________ Physician OB Email_____________________________

Practice Name: ___________________________ Phone Number______________ Fax Number: (___) ___________________

Address: _____________________________________ City/State: ____________________ Phone Number _______________

Items to Include

- Demographic sheet with Insurance Information
- ALL record and imaging reports from this pregnancy
- Lab work, genetic testing, amnio results
- Prenatal early screening results
- CD of images (if applicable)

Requested Appointments:

☐ Fetal Echo

☐ Fetal Ultrasound

☐ Fetal MRI

☐ Consult ________________

Notes: