# New Patient Referral/ Physician Order for BCH FCSC

**Boston Children's Hospital**
Fetal Care & Surgery Center

bostonchildrens.org/fcsc
617-355-6512 | *fax* 617-730-0124
FCSCReferrals@childrens.harvard.edu

Please **fill out all fields** and ensure that the form is **signed and dated by the ordering clinician**.

Submit the completed form via fax or email. **Fax: 617-730-0124**
**Email: FCSCReferrals@childrens.harvard.edu**

For all questions, call the Fetal Care and Surgery Center: **617-355-6512**.

## Patient information

First name: ______________________________________________

Last name: ______________________________________________

Date of birth: ________ Gender: ❍ M ❍ F ❍ Other: ___________

Address: _______________________________________________

City: _____________________ State/Province/Region: ___________

Zip/Postal code: ________________ Country: ________________

Phone: ___________________ ❍ Cell ❍ Home ❍ Office ❍ Other

Email: _________________________________________________

Preferred language: _____________ Interpreter needed? ❍ Yes ❍ No

Indication/Diagnosis: _______________________________________

Current anticipated delivery location: _________________________

Prior care for pregnancy or child at Boston Children's? ❍ Yes ❍ No

EDC:______________________ Gestational age: ______________

❍ Singleton ❍ Twins ❍ Other: ___________________________

## Insurance information

PCP (required for insurance): ________________________________

Insurance company: ______________________________________

Plan name: _____________________________________________

Insurance ID number: _____________________________________

## Referring physician information

**Physician name:** _________________________________________

Practice name: __________________________________________

Address: _______________________________________________

City: _____________________ State/Province/Region: ___________

Zip/Postal code: ________________ Country: ________________

Phone: ______________________ Fax: _____________________

Email: _________________________________________________

Physician specialty: ❑ OB ❑ MFM ❑ Cardiologist ❑ Other

**Primary OB** (if different)**:** ____________________________________

Practice name: __________________________________________

Address: _______________________________________________

City: _____________________ State/Province/Region: ___________

Zip/Postal code: ________________ Country: ________________

Phone: ______________________ Fax: _____________________

Email: _________________________________________________

## Requested appointments/Physician order:

❑ Fetal Echo ❑ Fetal MRI ❑ Fetal Ultrasound ❑ MFM Consult

❑ Consult: ______________________________________________

❑ Consult: ______________________________________________

❑ Other (please specify): _________________________________

❑ **Fetal Intervention**

## Items to include:

❑ Demographic sheet with Insurance Information

❑ ALL records and imaging reports from this pregnancy

❑ Lab work, genetic testing, amnio results

❑ Prenatal early screening results

❑ CD of images (if applicable)

## Requested timeframe schedule:

_______________________________________________________

_______________________________________________________

_______________________________________________________

_______________________________________________________

Please understand that appointments will be scheduled based on availability, as well as triaged clinical severity.

## Ordering clinician

❑ **CHECK THIS BOX** to refer to Boston Children's Hospital Fetal Care and Surgery Center for evaluation and treatment including diagnostic testing.

Name: _________________________________________________

Signature: ______________________________________________

Date: __________________________________________________