New Patient Referral/Physician Order for Fetal Cardiology Program

Boston Children's Hospital
Fetal Cardiology Program
bostonchildrens.org/fetalcardio
617-355-1499 | *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 Cardiology Program: **617-355-1499**.

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

Race: _____

Ethnicity: _____

Clinical Information

EDC:_____ Gestational age: _____

❍ Singleton ❍ Twins ❍ Other: _____

Suspected Cardiac Diagnosis: _____

Other suspected anomalies: _____

Genetic testing: _____

Other issues (social/financial/transportation/other):

_____

Current anticipated delivery location: _____

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

Insurance information

PCP (required for insurance): _____

Insurance company: _____

Plan name: _____

Insurance ID number: _____

Referring cardiologist information

Referring Cardiologist Name: _____

Practice name: _____

Address: _____

City: _____ State/Province/Region: _____

Zip/Postal code: _____ Country: _____

Phone: _____ Fax: _____

Cardiologist email: _____

Primary OB or MFM (if different)**:** _____

Practice name: _____

Address: _____

City: _____ State/Province/Region: _____

Zip/Postal code: _____ Country: _____

Phone: _____ Fax: _____

Email: _____

Scheduling timeframe requests:

❏ Schedule fetal echo in_____ weeks.
Please coordinate appointment with doctor: _____

❏ Schedule fetal echo and US/MRI/other specialists: _____
_____

❏ Establish care for Boston delivery. Please schedule same-day appointments in _____ weeks for a fetal echocardiogram and consultation with Dr. _____ and a MFM consultation for delivery planning.

When feasible, please allow 3–4 weeks' advance notice to coordinate same-day fetal echo and MFM visits.

Additional notes:

_____

_____

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

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

Ordering clinician

❏ **CHECK THIS BOX** to refer to Boston Children's Hospital Fetal Cardiology Program for evaluation and treatment including diagnostic testing.

Name: _____

Signature: _____

Date: _____