NEW Fetal Cardiac Referral/Physician Order for MFCC

Please send this form and patient information (demographics, insurance, OB/cardiology medical records) by fax (617-730 0124) or email (MFCCReferrals@childrens.harvard.edu). For any questions please call the Maternal Fetal Care Center at (617) 355-6512.

Please fill out ALL fields. REFERRING PHYSICIAN MUST SIGN AND DATE FORM TO BE USED AS AN ORDER.

| Patient Name: ___________________________ | Maiden Name: ___________________________ | DOB: ___________________________ |
| Home Address: ___________________________ | City: ___________________________ | State: ______ | Zip: ___________ |
| Cell Phone: (___) ___________ | Home Phone Number: (___) ___________ | Interpreter: (Y/N) ___________ |
| Email: ___________________________ | Insurance Company: ___________________________ |
| Plan Name: ___________________________ | Insurance ID Number: ___________________________ | Subscriber: ___________________________ |

Suspected Cardiac Diagnosis: __________________________________________________________

Other suspected anomalies or chromosome problems: _______________________________________

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

EDC: _______ | Current Gestational Age: _______ | Singleton: _______ | Twins: _______ | Other: _______ | PCP: ___________________________

Current anticipated delivery location: ___________________________ | Prior pregnancy/child care at BCH (Y/N): _______ |

If you have any insurance related questions, please contact Boston Children’s Hospital patient financial services at 617-355-3397 for help. Thank you!

Referring Cardiologist Information:

| Referring Cardiologist Name: ___________________________ | Cardiologist Email: ___________________________ |
| Practice Name: ___________________________ | Practice Phone Number: (___) ___________ | Practice Fax Number: (___) ___________ |
| Address: ___________________________ | City: ___________________________ | State: ______ | Zip: ___________ |

Primary OB or MFM Name: ___________________________ | Practice Phone: (___) ___________ |

Practice Name: ___________________________ | Practice Fax Number: (___) ___________ |

Address: ___________________________ | City: ___________________________ | State: ______ | Zip: ___________ |

Scheduling Requests:

☐ Schedule fetal echo in ________ weeks. Please coordinate appointment with Dr. __________________.

☐ Schedule fetal echo and US/MRI/other specialists: ___________________________

☐ Establish care for Boston delivery and schedule same day appointment in ________ weeks for a fetal echo coordinated with Dr. __________________ and BWH MFM appointment. When possible, please try to provide 3-4 weeks notice to request same day appointments. Please ask your patient to call and register at BWH today so that appointments can be scheduled (866-489-4056).

☐ Email Final echo reports to: ___________________________

☐ Additional Notes: ___________________________

☐ CHECK THIS BOX to refer to Boston Children’s Hospital MFCC for evaluation and treatment including diagnostic testing.

Physician Signature ___________________________ Date ___________________________

If this form is not fully completed, this may delay patient care. Please always try to refer to us as soon as possible.