



### 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](mailto: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.**