# Memorial Maternal Fetal Medicine

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**South Bend, Indiana**
**(574) 647-1650 • Fax (574) 647-1655**


## Patient Referral Form

Date of Referral_____ Phone_____
Referring Physician_____ Fax_____
Address_____ Contact Person_____

***Referral forms received after 4pm will be processed the next business day.***

**Patient Information:**

Last Name_____
First Name_____MI_____
Address_____
City_____
State_____Zip_____
Home Phone ( )_____
Work/Cell ( )_____
DOB_____Age_____
Social Security #_____
Employer_____

**Please fax/forward the following information with the referral form to (574) 647-1655 & place a check mark (√) beside the items forwarded:**

- ☐ Prenatal Labs
- ☐ Pap Test
- ☐ GC/Chlamydia
- ☐ HIV
- ☐ Blood glucose monitoring results
- ☐ Prenatal/Medical Records
- ☐ U/S Reports for current pregnancy
- ☐ Autopsy/Pathology Reports (if fetal demise)
- ☐ Pertinent Records from other physicians
- ☐ Copy of insurance card

LMP_____EDC_____
Current GA_____Sono Date_____
GA then _____Blood Type_____

If Referral for GDM/IDDM:
GTT Results: FBS___1°____2°____3°____
Hgb $A_1C$_____
Dietary Consult Done: ☐ Yes ☐ No

**Referral Information:**

(Reason/Diagnosis for Referral & Other Pertinent Information)

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**Please place a check mark (√) by one of the following:**

- ☐ Consult Only
- ☐ Consult & Co-Manage

***MMFM Use Only***

Appointment Date_____Time_____
Referral Office Contacted_____