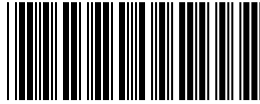
Lucile Salter Packard Children's Hospital
STANFORD UNIVERSITY MEDICAL CENTER
725 Welch Road Palo Alto, CA 94304



**ORDERS • CFMH**
**REFERRING PHYSICIAN ORDERS**

Medical Record Number

Patient Name

Addressograph or Label – Patient Name, Medical Record Number

Physician: Check all orders that pertain to the patient. Date, time & sign all orders.

Center for Comprehensive Fetal AND Maternal Health (English): (650) 724-2221
CFMH (Spanish)/Genetic Counseling: (650) 723-5198

## PROCEDURE/EVALUATION REQUESTED

**ICD-9 Code** ________________

- ❑ OB Ultrasound (with consultation if applicable)
- ❑ Amniocentesis/OB Ultrasound (will include Genetic Counseling)
- ❑ Fetal echocardiogram
- ❑ Fetal MRI/Ultrasound (with Genetic Counseling if applicable)
- ❑ Genetic Counseling Only
- ❑ Non-Stress Test
- ❑ Amniotic Fluid Index
- ❑ Umbilical Artery Doppler/Ultrasound
- ❑ Middle Cerebral Artery Doppler/Ultrasound
- ❑ Consult for Delivery
- ❑ Transfer of OB Care

## REASON FOR REFERRAL

- ❑ Suspected fetal anomaly:
  Describe: ______________________________________________________________

- ❑ Previous history of _________________
- ❑ Family history of ___________________
- ❑ Detailed anatomy evaluation
- ❑ Suspected teratogen exposure ______________
- ❑ Decreased fetal movement
- ❑ Suspected macrosomia
- ❑ Suspected IUGR
- ❑ Oligohydramnios
- ❑ Polyhydramnios
- ❑ Multiple gestation
- ❑ Diabetes
- ❑ Pre-eclampsia
- ❑ Placental Abnormality (previa, accreta, etc)
- ❑ Isoimmunization – Rh or other _____________
- ❑ Hypertension
- ❑ Uterine abnormality
- ❑ Antiphospholipid syndrome/thrombophilias
- ❑ Premature labor abnormality:
  Describe ___________________________
- ❑ Other: _____________________________
  _____________________________________

(Genetic Counseling will be provided if indicated)

**Fax to CFMH (650) 723-6607**

*****Please include all laboratory results, ACOG flow sheets, consultation and imaging reports*****

| DATE | TIME | Provider Signature: | Pager: | Noted by: | Date/Time |
|---|---|---|---|---|---|
| Orders signed | | **PRINT** Provider Name: | | RN Signature | Date/Time |

L15208.11.09 (Rev. 10.10)