WILLIAMSON HEALTH
Medical Group

MATERNAL FETAL MEDICINE
Chelsea Clinton, MD | Michael DeRoche, MD
4323 CAROTHERS PARKWAY, SUITE 403
FRANKLIN, TN, 37067
(615) 435-7750 Fax (615) 435-7754

DATE: _____

REFERRAL FORM

PATIENT DEMOGRAPHIC INFORMATION:

LMP: _____ **ESTIMATED DUE DATE: _____/_____/_____** → **BASED ON _____**

Gravida (G): _____ **Para (P): _____**

Pre-pregnancy Weight: _____ **Height: _____**

Patient's Last Name: _____ First: _____ M: _____

Date of Birth: _____/_____/_____ Primary Phone Number: (_____) _____

Address: _____ City/ST/Zip: _____

REQUIRED RECORDS TO BE SENT WITH REFERRAL: *All records pertaining to the pregnancy must be attached, including but not limited to:*

☐ Ultrasound Reports
☐ Lab Results
☐ Prenatal Progress Notes
☐ Genetic Testing Results (if applicable)

INSURANCE INFORMATION: (Please attach a copy of the front and back of the insurance card)

Insurance Company: _____

Policy #: _____

Referring Provider Name: _____ **Office Phone: _____ Office Fax: _____**

ORDER & REASON FOR REFERRAL (Diagnosis/Concern REQUIRED):

Does the patient need:

☐ Ultrasound only
☐ Consult with MFM physician
☐ Both ultrasound & consult
☐ Consult if indicated beyond ultrasound findings

ULTRASOUND TYPE (IF APPLICABLE):

☐ Anatomy Ultrasound
☐ Amniocentesis
☐ Biophysical Profile (BPP)
☐ Dating Ultrasound (1st Trimester)
☐ Fetal Echocardiogram
☐ Growth Ultrasound
☐ Gynecological Ultrasound
☐ Follow-up Anatomy Ultrasound
☐ Other (please specify):

_____

INDICATION FOR REFERRAL:

☐ Preconception Counseling
☐ Diabetes Management
☐ Hypertension/Preeclampsia
☐ Obesity
☐ Cervical Shortening / Insufficiency
☐ Fetal Growth Restriction
☐ Multi-fetal Gestation
☐ Genetic Counseling
☐ Other (please specify):

_____

Please complete form with the required records and fax back to 615-435-7754. Thank you!