UCDAVIS HEALTH | CHILDREN'S HOSPITAL

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Sacramento, CA 95817
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Fetal Care and Treatment Center (FCTC) Referral

Please fax this form to **(916) 734-4452**. Call **(916) 794-BABY** with any questions.

Suspected Fetal Anomaly: _____

Referral Indication/Services Requested: _____

Patient name: _____ Phone number: _____

Date of birth: _____ LMP: _____ EDD: _____

G: _____ P: _____ Patient Weight: _____

Translator needed? No ____ Yes____ (language): _____

Referring provider name: _____

Office phone: _____ Office fax: _____

Office address: _____

Primary OB (if not referring provider): _____

Services requested:

☐ Fetal Ultrasound

☐ Fetal ECHO/Cardiology

☐ Fetal MRI

☐ Fetal Intervention/Surgery

☐ Prenatal consult with subspeciality: _____

_____

☐ Other: _____

Please fax the following information to (916) 734-4452:

- Insurance information (front and back of card)
- Patient Demographic Sheet
- Obstetrical records including:
  - Prenatal records with medical and pregnancy history
  - Ultrasound Reports
  - Prenatal labs
- State Screening/Prenatal Screening
- NIPS (Harmony, MaterniT 21, Panorama)
- Amniocentesis/CVS results (karyotype/microarray)

23-0296 (5/23)