UCDAVIS HEALTH

MATERNAL FETAL MEDICINE & PRENATAL DIAGNOSIS
DEPARMENT OF OBSTETRICS AND GYNECOLOGY
ATTN: Referral Coordinator
Phone: 916-734-6900 Fax: 916-703-5279
Email: maternalfetalmedicine@health.ucdavis.edu

Date: _____

Referring Provider: _____ Office Contact: _____ Phone: _____ Fax: _____

PATIENT NAME _____ DOB _____ SS#_____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

TELEPHONE (h) _____ (w) _____ LANGUAGE _____

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PLEASE ATTACH COPY OF INSURANCE CARD

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LMP _____ GEST AGE _____ FATHER OF THE BABY'S AGE _____

FINAL EDD _____ based on ____ LMP or ____ ULTRASOUND at _____ (date and EGA)

GRAVIDA ____ TERM____ PRETERM ____ TAB ____ SAB ____ ECT ____ PRIOR NSVD_____ C/S _____

BLOOD TYPE _____ BMI _____ IVF _____ (transfer date, age at retrieval, and egg donor)

ICD10:_____

PLEASE SEND ALL OF THE FOLLOWING RECORDS WITH THIS FORM:

1.ULTRASOUND REPORTS
2. PRENATAL LABS
3.GENETIC TESTING NIPTs CA cfDNA CA MSAFP, Carrier Screening
4.PRENATAL RECORDS
5.OTHER PERTINENT INFORMATION (operative reports, discharge summaries, EKGs, echo reports, past delivery records, etc.)

Our physicians need all of information above to provide comprehensive consultative services. Patients will only be contacted if their prenatal records are available.

Please select from the options below:

☐ Transfer of Care
☐ Consult and if higher level of care is needed, assume care

Updated 07022025