CentraCare
St. Cloud Hospital
Women & Children's Center

Center for Advanced Maternal, Fetal & Newborn Care

PERINATOLOGY CLINIC
Provider Service Request

Today's Date: _____ Patient Name: _____
DOB: _____
Home Phone: _____ Cell Phone: _____

Provider Name/Clinic: _____
Contact person at clinic: _____ Phone:_____ Fax: _____

TELEHEALTH SITE: _____

ULTRASOUND: **All OB ultrasounds are interpreted by the MFM physician and results discussed with the patient. This may include consultation on ultrasound findings, suggestion for fetal surveillance related to indication or findings, *but does not include* an extended consult for pregnancy management due to maternal condition or prior pregnancy complications, unless requested below. Genetic counseling, ultrasound or additional testing may be included in the visit, as recommended per MFM clinic protocol.**

INDICATION(s): _____

- ❑ **First Trimester Ultrasound** (<14 weeks gestation)
- ❑ **First Trimester Screening** (Nuchal Translucency + Serum) including complete ultrasound
- ❑ **Non-Invasive Prenatal Testing (NIPT)** (Verify) including complete ultrasound and genetic counseling
- ❑ **Genetic Amniocentesis** including genetic counseling
- ❑ **Transvaginal Ultrasound** (check cervical length)
- ❑ **Complete Ultrasound** (growth and anatomy up to 18 weeks)
- ❑ **Level II (Detailed Anatomic) Ultrasound** (>18 weeks gestation) including detailed fetal anatomic assessment with fetal echo per MFM clinic protocol
- ❑ **Fetal Echocardiogram** Maternal indication_____Fetal indication _____
- ❑ **Follow-Up Ultrasound** After MFM has completed a Level II (detailed anatomic) ultrasound

❑ **CONSULTATION:** **MFM consult is an additional 30-60 minutes for face-to-face discussion of preconceptual counseling, pregnancy management for medical conditions or prior pregnancy complication, with testing as determined and ordered by Perinatologist.**
Reason for consultation (Indication/Diagnosis): _____
_____

PLEASE complete and fax provider service request, along with the following information: A complete current prenatal record and all associated ultrasounds, labs (including blood type report, triple/quad screen report) and a demographic sheet.

Provider Signature: _____ Date: _____

St. Cloud Hospital Perinatology Clinic
Phone: (320) 656-7024 Fax: (320) 656-7026