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Phone: 214.377.7252
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Today's Date: ________________

Referring Provider: ____________________________________ Phone: ______________________

Patient's Name: ____ DOB: _____________________

Cell Number: ____ EDD: ___________________

Multiples: □Y □N Patient has a follow-up appointment on: ______________________

Reason for referral: ____

____

- □ Fetal Anatomy Sono
- □ Genetic Counseling
- □ Cervical Assessment
- □ NT/Screening/Testing

  Known Abnormalities or Genetic History □ Y □ N
- □ Other ___________________________________

I have attached the following records:

- □ Demographics
- □ Current Prenatal Flow Sheet
- □ Pertinent Labs
- □ Cell-Free Fetal DNA/NIPT
- □ Genetic Screening
- □ Other

****Please do not send entire nonpregnant medical record if not pertinent to visit****

Appt Date: __________________ Time: _______________ EGA: ______

Scheduled by: ___________________________ on Date: ________________

Revised 12/2023