



# Saint Alphonsus

## Maternal-Fetal Medicine

### Boise

900 N Liberty St, #206  
Boise, ID 83704  
Phone (208) 302-1100

### Nampa

4424 E Flamingo, #220  
Nampa, ID 83687  
Phone (208) 302-1100

Please submit the following information to assist our practice in providing a quality consultation:

☐ Face Sheet ☐ Prenatal Records ☐ Prenatal Labs ☐ OB Ultrasounds ☐ NIPT/Carrier Screening Reports

**Records must be received prior to patient scheduling. Fax to (208) 302-1155**

Referring Provider: \_\_\_\_\_ Referring Provider Phone: \_\_\_\_\_

Office Contact: \_\_\_\_\_ Office Contact Email: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_

Patient needs (language, transportation, etc.): \_\_\_\_\_

**Maternal Indications:**

**Fetal Indications:**

### Obstetric Ultrasound\*

LMP: \_\_\_\_\_ EDC: \_\_\_\_\_ EDC based on LMP/Ultrasound \_\_\_\_\_ Dating US on \_\_\_\_\_ GA \_\_\_\_\_

Number of Fetuses \_\_\_\_\_

- ☐ Viability/Dating < 14 weeks
- ☐ First Trimester Screening/Nuchal Translucency (11w0d– 13w6d) (includes genetic counseling & NIPT)
- ☐ Fetal Anatomy Ultrasound ONLY
- ☐ Detailed anatomy ultrasound & MFM consult (see below)- including but not limited to: known or suspected abnormality or increased risk; AMA; Obesity; HTN; pregestational diabetes; drug exposure; twins
- ☐ Growth/Repeat ultrasound - reevaluation of fetal size and/or reevaluation of specific organ(s) known or suspected to be abnormal
- ☐ Serial cervical length (16-24 weeks) (includes MFM consultation)
- ☐ Limited - amniotic fluid volume; placental location
- ☐ Biophysical Profile

\*If a patient is pregnant and referred to Saint Alphonsus MFM for a consultation, an ultrasound will be performed in conjunction with the consult, unless previously done at another MFM office.

### Maternal Fetal Medicine

- ☐ MFM pre-pregnancy consultation
- ☐ MFM obstetric consultation (one time visit with no expectation for follow up)
- ☐ MFM obstetric co-management (follow up as determined by MFM)

### Genetic Counseling

- ☐ Preconception (recurrent pregnancy loss, family history, prior child with abnormality, maternal age, etc.)
- ☐ Current pregnancy (review risk-appropriate screening options, discuss abnormal result, family history, etc.)
- ☐ Other \_\_\_\_\_

**Diagnostic Testing** Patient blood type \_\_\_\_\_

- ☐ Amniocentesis ☐ CVS

**\*\*SPECIFIC INDICATION FOR CONSULT MUST BE LISTED ABOVE.\*\***

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_