TENNESSEE MATERNAL FETAL MEDICINE, PLC
300 20TH Avenue North, Suite 702, Nashville, TN 37203
1800 Medical Center Pkwy, DePaul Blg. Ste 320 Murfreesboro, TN 37129
100 Covey Dr, Suite 207, Franklin, TN 37067
(615) 284-8636 Fax (615) 284-8637

CONSULTATION & DIAGNOSTIC TESTING REQUEST

LOCATION: ☐ NASHVILLE (M-F) ☐ MURFREESBORO (M- Th) ☐ FRANKLIN (M- Th)

APPOINTMENT DATE: _____/_____/_____ TIME: _____ AM PM

PATIENT DEMOGRAPHIC DATA:

Pt's Last Name: _____ First: _____ M: _____

Date of Birth: _____/_____/_____ Soc Sec #: _____-_____-_____

Address: _____ City/ST/Zip: _____

Primary Phone Number: (_____) _____ Work Phone: (_____) _____

G _____ P_____ LMP _____ Estimated Date Confirmation _____/_____/_____

INSURANCE CO: _____ Phone #: (_____) _____

Subscriber's Name: _____ Relationship to Pt: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Date of Birth: _____/_____/_____ Soc Sec #: _____-_____-_____

Ins. ID #: _____ Group #: _____

CONSULTATION REQUEST:

☐ CONSULT w/Diagnostic Testing, as clinically indicated & subsequent Co-Management

☐ CONSULT w/ Diagnostic Testing, as clinically indicated

PRINT PHYSICIAN NAME: _____

PHYSICIAN SIGNATURE: _____ NPI #: _____

***For TMFM Use Only, Please**
Verbal Order Taken by _____ Date: ____/____/_____ From: _____

DIAGNOSTIC TESTING REQUEST - PLEASE CHECK DIAGNOSTIC TEST ORDERED

- ☐ Anomaly Screening (18-20 WEEKS)
- ☐ ≤ 14 Weeks Scan
- ☐ ≥ 14 Weeks Scan
- ☐Follow Up Ultrasound
- ☐Biophysical Profile (BPP)
- ☐ Cervical Length
- ☐Amniocentesis
- ☐ Chorionic Villus Sampling (CVS)
- ☐ GYN Ultrasound Transabdominal & Transvaginal
- ☐ Postpartum Diabetes Management (E&M Visit)
- ☐ Diabetes Management (E&M Visit)
- ☐ Coumadin Management
- ☐ Doppler Flow Study
- ☐ NT Lab Draw Between 9-13 Weeks for IRA
- ☐ Nuchal Translucency Screening W/Consult
- ☐ Dx - Other _____

PT. BLOOD TYPE: _____

** CMS Program Memorandum AB-01-144 Change Request - Effective January 1, 2002 referring diagnosis is required for diagnostic testing. Suspected or rule-out statements are NOT applicable, if no confirmed diagnosis, PLEASE list symptoms.*

DIAGNOSIS/REASON FOR REFERRAL:

- ☐ Known/Suspected Fetal Abnormality
- ☐ Advanced Maternal Age
- ☐ Cervical Incompetence
- ☐ Multiple Gestations ____#
- ☐ Prior Fetal Loss
- ☐ Early/Threatened Labor
- ☐ Large for Dates
- ☐ Small for Dates
- ☐ CHTN
- ☐ Thrombophilia
- ☐ Polyhydramnios
- ☐ Oligohydramnios
- ☐ Congenital Disorder
- ☐ Endocrinologic Disease
- ☐ Hematologic Disease
- ☐ Infectious Disease
- ☐ Drug Exposure
- ☐ Diabetes Mellitus I or II
- ☐ GDM
- ☐ Gastrointestinal Disease
- ☐ Neurological
- ☐ Renal Disease
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____

Please sign and fax with any pertinent clinical information to 615-284-8637. Thank you! *Feb 2012*