ADVANCED MATERNAL FETAL CENTER OF GLENDALE

Kevin Justus, MD, FACOG
Steve Rad, MD, FACOG
Maternal Fetal Medicine

1577 E Chevy Chase Dr #300, Glendale, CA 91206
Office: 818-240-8300 • Fax: 818-240-8303
mfmglendale.com • info@mfmglendale.com

# REQUEST FOR MATERNAL-FETAL MEDICINE SERVICES

Please fax or email completed order to 818.240.8303 • info@mfmglendale.com

## 1. Patient information:

Patient Name: Last_____ First _____ Phone: ( ) _____ – _____

Age: _____ DOB: _____ /_____ /_____ SS# ____-_____-_____ Height _____ Weight _____

G _____ P (TPAL) _____ LMP _____ /_____ /_____ EDD (Best) _____ /_____ /_____ (by ☐ US ☐ LMP)

Current GA _____weeks ☐ Singleton ☐ Multiple ☐ IVF/Other ART ☐ Prior cesarean

Address: _____ City: _____ ST_____ ZIP _____

Insurance (include copy):_____

Additional information (relevant medical history): _____

## 2. Requested Services: choose all that apply

### Ultrasound/Procedure

- ☐ Gynecologic ultrasound
- ☐ 1st Trimester ultrasound
- ☐ NT exam + 1st Trimester, TRF# _____
- ☐ Early Fetal Anatomy/Echo
- ☐ Detailed Fetal Anatomic Survey (rule out/suspected anomalies)
- ☐ Fetal Echo
- ☐ Cervical Length (endovaginal)
- ☐ Amniocentesis
- ☐ Cerclage
- ☐ 3rd Trimester/Fetal Growth, Indication: _____
- ☐ Placental location and/or abnormal condition
- ☐ AFI evaluation
- ☐ Antenatal Testing (NST+ AFI)
- ☐ BPP
- ☐ Doppler Studies
- ☐ Other: _____

*Note: All visits may include additional procedures, consultations, E&M,and follow-up as deemed clinically indicated at time of visit.

## 3. Requested Services: choose all that apply

### Consultation

- ☐ Preconception Consult _____
- ☐ Perinatology Consult _____
- ☐ Genetic Counseling
- ☐ Advanced Maternal Age
- ☐ Positive Prenatal Screen
- ☐ Family History
- ☐ Multifetal gestation
- ☐ Medication, teratogen, viral (Zika) or other exposure
- ☐ Diabetes Co-Management
- ☐ Hypertension Co-Management
- ☐ Thyroid abnormality
- ☐ Placenta Accreta
- ☐ Maternal Medical Condition or Co-Management of Other High Risk Pregnancy_____

- ☐ Delivery Planning
- ☐ Second Opinion
- ☐ International Patient
- ☐ Concierge Services
- ☐ Telehealth (Remote) Services
- ☐ Home Visit
- ☐ *Inpatient* _____
- ☐ *Urgent*

## 4.

*** PLEASE FAX ALL RELEVANT MEDICAL, PRENATAL, LAB, & SCREENING RECORDS ***

Ordering Provider: _____ Contact Name:_____ Phone/Pager: ( ) _____ – _____Fax: ( ) _____ – _____

Today's Date: _____ /_____ /_____ (*Appointment Date (Office Use)*: _____ /_____ /_____)

*We gladly accept most insurance plans. Thank you for your referral and trust in our services!*