NEW Fetal Cardiac Referral/Physician Order for MFCC

Please send this form and patient information
(demographics, insurance, OB/cardiology medical records)
by fax (617-730 0124) or email (MFCCReferrals@childrens.harvard.edu) .
For any questions please call the Maternal Fetal Care Center at (617) 355-6512.
Please fill out **ALL** fields-**REFERRING PHYSICIAN MUST SIGN AND DATE FORM TO BE USED AS AN ORDER**.

Patient Name: _____ Maiden Name:_____ DOB: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: (___) _____ Home Phone Number: (___) _____ Interpreter: (Y/N) _____

Email:_____ Insurance Company: _____

Plan Name: _____ Insurance ID Number: _____ Subscriber: _____

Suspected Cardiac Diagnosis:_____

Other suspected anomalies or chromosome problems:_____

Other issues (social/financial/transportation/other): _____

EDC: _____Current Gestational Age: _____Singleton:_____ Twins: _____ Other: _____ PCP: _____

Current anticipated delivery location: _____ Prior pregnancy/child care at BCH (Y/N): _____

If you have any insurance related questions, please contact Boston Children's Hospital patient financial services at 617-355- 3397 for help. Thank you!

Referring Cardiologist Information:

Referring Cardiologist Name: _____ Cardiologist Email: _____

Practice Name: _____Practice Phone Number: (___)_____Practice Fax Number: (___)_____

Address: _____ City: _____ State: _____ Zip: _____

Primary OB or MFM Name: _____ Practice Phone: (___) _____

Practice Name: _____ Practice Fax Number: (___) _____

Address: _____ City: _____ State: _____ Zip: _____

Scheduling Requests:

□ Schedule fetal echo in _____weeks. Please coordinate appointment with Dr. _____.

□ Schedule fetal echo and US/MRI/other specialists:_____.

□ Establish care for Boston delivery and schedule same day appointment in _____ weeks for a fetal echo coordinated with Dr. _____ and BWH MFM appointment. When possible, please try to provide 3-4 weeks notice to request same day appointments. Please ask your patient to call and register at BWH today so that appointments can be scheduled (866-489-4056).

□ Email Final echo reports to: _____

□ Additional Notes:

□ **CHECK THIS BOX to refer to Boston Children's Hospital MFCC for evaluation and treatment including diagnostic testing.**

Physican Signature Date

If this form is not fully completed, this may delay patient care. Please always try to refer to us as soon as possible.