M HEALTH
MATERNAL-FETAL MEDICINE CENTERS
MFM Provider Service Request OUTpatient

☐ **Maternal-Fetal Medicine Center, Minneapolis**
Riverside Professional Building
Phone: 612-273-2223 Fax: 612-273-2224

☐ **Maternal-Fetal Medicine Center, Burnsville**
Ridgeview Medical Building
Phone: 952-892-2270 Fax: 952-892-2275

☐ **Maternal-Fetal Medicine Center, Edina**
Southdale Medical Building
Phone: 952-924-5250 Fax: 952-924-5251

☐ **Maternal-Fetal Medicine Center, Maplewood**
Maplewood Professional Building
Phone: 651-326-7199 Fax: 651-326-7179

Patient Name: _____
Patient Address: _____
DOB: _____/_____/_____(mm/dd/yyyy)
Home Phone #: (_____) _____ – _____
Work Phone #: (_____) _____ – _____
Cell Phone #: (_____) _____ – _____
Interpreter: Y / N Language: _____

Priority: ☐ High (will be scheduled within 72 hrs)
☐ First Available/Patient Convenience **(If priority not selected will assume first available)** Date: _____

Prenatal Provider Name: _____ Clinic Contact Person: _____
Referring Clinic/Site: _____ Clinic Phone #: (_____) _____ – _____
Clinic Fax #: (_____) _____ – _____

EDD:_____ LMP:_____ Patient BMI:_____ Please Circle: SINGLE TWIN TRIPLET QUAD MORE _____

ULTRASOUND (US) - Reason for Ultrasound (Indication/Diagnosis): _____
*Patients will receive ultrasound interpretation only by the Maternal Fetal Medicine Specialist

☐ **First Trimester Ultrasound** (less than 14 weeks gestation)
☐ **First Trimester Screening** (Nuchal Translucency Ultrasound and Blood Test)**.** (11 to 13 weeks 6 days gestation) * *Patient will also be scheduled for genetic counseling for this service.*
☐ **Transvaginal Ultrasound (for cervical length assessment)**
☐ **Complete 2/3 Trimester Ultrasound** (**14-18 weeks gestation**)
☐ **Comprehensive Ultrasound** (**≥18 weeks gestation**) – fetal and maternal evaluation including biometry & a detailed anatomy evaluation.
☐ ***Follow- Up Ultrasound** ***(*ONLY ORDERED/ USED AFTER MFM HAS COMPLETED A COMPREHENSIVE U/S)***

FETAL ECHOCARDIOGRAM
*Requests will be reviewed by MFM staff prior to scheduling to determine appropriate location for exam to be performed.
☐ **Fetal Echocardiogram**
☐ Maternal Indication:_____ ☐ Fetal Indication:_____

PROCEDURE - Reason for Procedure (Indication/Diagnosis): _____

☐ **Cell-Free DNA Screen** ** Patient will also be scheduled for genetic counseling for this service*
☐ **Genetic Amniocentesis** (generally 16 weeks gestation) ** Patient will also be scheduled for genetic counseling for this service.*
☐ **Chorionic Villus Sampling** – (10+0 to 13+6 weeks gestation) ** Patient will also be scheduled for genetic counseling for this service.*

FETAL SURVEILLANCE – Reason for Fetal Surveillance (Indication/Diagnosis): _____
*Growth and anatomy assessments are **NOT** included with fetal surveillance.

☐ **Biophysical Profile w/o NST (BPP)** – Begin at _____ ☐ one time only ☐ weekly ☐ twice weekly
☐ **Biophysical Profile with NST (BPP/NST) -** Begin at _____ ☐ one time only ☐ weekly ☐ twice weekly
☐ **Non-Stress Test (NST)** - Begin at _____ ☐ one time only ☐ weekly ☐ twice weekly
*If NST non-reactive, will proceed to BPP.

CONSULTATION - Reason for Consultation (Indication/Diagnosis): _____
Specific reason for request (issue/concern): _____
*Consultation orders will be reviewed by MFM staff prior to scheduling appointment(s). Consultation Report includes Summary and Recommendations by the Maternal Fetal Medicine Specialist and/or Genetic Counselor.

☐ **Maternal-Fetal Medicine Consultation** ☐ **Genetic Counseling Consultation**
☐ **Inflammatory Bowel Disease Clinic: Joint MFM and GI consultation**

***Patient may proceed with recommendations for further testing as directed by Maternal-Fetal Medicine Specialist**

PROVIDER SIGNATURE: _____ DATE: _____ TIME: _____

PROVIDER NAME (print): _____ PAGER #: _____

****This signed order is required prior to any appointments with MFM.**

PLEASE FAX: PATIENT'S CURRENT DEMOGRAPHIC INFORMATION, PRENATAL RECORD, PRENATAL LABS AND ULTRASOUND REPORTS.