PRINT SAVE AS EMAIL RESET

Legacy Medical Group–Maternal-Fetal Medicine Referral Form

LEGACY HEALTH

☐ **Legacy Emanuel Campus**
Medical Office Building 3
300 N. Graham St., Suite 100
Portland, OR 97227
Phone: 503-413-1122
Fax: 503-413-4238

☐ **Legacy Salmon Creek Campus**
Medical Office Building B
2101 N.E. 139th St., Suite 260
Vancouver, WA 98686
Phone: 360-487-2870
Fax: 360-487-2879

☐ **Clackamas Campus**
One Town Center
10151 S.E. Sunnyside Road, Suite 315
Clackamas, OR 97015
Phone: 503-414-5700
Fax: 503-413-4238

Date: _____

Patient's name:		Patient's home number:
Patient's date of birth:	Social Sec #:	Patient's home address:
Referring physician/provider:		Referring physician's address:
Referring physician's phone:		Referring physician's fax:
Referring physician's signature:		Interpreter required: ☐ Yes ☐ No If yes – what language:

Primary insurance:	Phone:	Secondary insurance:	Phone:
Subscriber's name:	Date of birth:	Subscriber's name:	Date of birth:
Policy number/group number:		Policy number/group number:	

By LMP _____ By U/S _____
If so, date of first U/S _____, gestational age at that time _____

Reason for referral/diagnosis: _____

CHOOSE FROM CONSULT, US, AND GENETICS. THEN, CIRCLE SPECIFIC INDICATION LISTED BELOW.

☐ **Consult** (w/US and GC if needed)
- ☐ Assume care for _____
- ☐ Share care for _____
- ☐ Abnormal US _____
- ☐ Prepregnancy consult for _____
- ☐ Fetal Care Coordinator
- ☐ Other _____

☐ **Ultrasound** (w/consult or GC if needed)
- ☐ Dating/Viability
- ☐ First trimester screening (<35 at del.)
- ☐ Anatomy
- ☐ Growth
- ☐ Abnormal US
- ☐ Cervical length
- ☐ BPP or AFI/NST
- ☐ Amnio/CVS
- ☐ Fetal Echo
- ☐ Other _____

☐ **Genetics** (w/consult or US if needed)
- ☐ >35 at delivery (with US if needed)
- ☐ Review all testing options
- ☐ cfDNA <35 at delivery (with US if needed)
- ☐ Abnormal screening
- ☐ Abnormal US
- ☐ Carrier screening
- ☐ Family history of _____
- ☐ Amnio/CVS
- ☐ Prepregnancy
- ☐ Other _____

Office Use Only:

Initial: _____