The Children's Hospital of San Antonio™
CHRISTUS Health

Baylor College of Medicine

Center for Maternal and Fetal Care

Center for Maternal and Fetal Care Referral Request Form

☐ **The Children's Hospital of San Antonio**
Professional Pavilion
315 San Saba, Suite 930
San Antonio, Texas 78207
p: 210.704.3200
f 210.704.2718

☐ **CHRISTUS Santa Rosa - Westover Hills**
Medical Plaza 1, Suite 300
11212 State Highway 151
San Antonio, Texas 78251
p: 210.703.8200
f: 210.520.0663

☐ **New Braunfels - Telemedicine**
CHRISTUS Santa Rosa
Imaging Center
598 North Union Ave, 1st Floor
New Braunfels, Texas 78130
p: 210.703.8200
f: 210.520.0663

Date: _____

Priority: ☐ High (will be scheduled within 72 hours)
☐ First available/patient convenience

Patient Information

Patient Name: _____
Date of Birth (mm/dd/yyyy): _____
Patient Address: _____
_____
Home Phone #: _____
Work Phone #: _____
Cell Phone #: _____

Provider Information

Prenatal Provider Name: _____
Referring Clinic Site: _____
Clinic Contact Person: _____
Clinic Phone #: _____
Clinic Fax #: _____

EDD: _____ LMP: _____ Check: ☐ Single ☐ Twins ☐ Triplets ☐ More: _____

Reason for Referral: _____

Services Requested (Please check all that apply)

☐ Comprehensive fetal evaluation as deemed necessary by the Center for Maternal and Fetal Care
☐ Consultation
- ☐ Maternal Fetal Medicine
- ☐ Genetic Counseling
- ☐ Pediatric Cardiology/fetal echo

☐ Co-management with Center for Maternal and Fetal Care

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

Please fax this form, along with all patient medical records, including labs, ultrasounds and demographic info (including patient insurance information).

Provider Signature: _____ Date: _____ Time: _____

Provider Name (Print): _____ Pager #: _____

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