UNIVERSITY OF IOWA HOSPITALS AND CLINICS
UI Women's Health Center: Fetal Diagnosis Referral Fax Cover Sheet

FAX COVER SHEET: If this is an urgent request please call 319-356-2294.

Patient Name_____Last 4 Digits SSN_____DOB_____

Address_____

Phone_____Patient Primary Language_____

Type of Insurance_____

Emergency contact name_____Phone_____

Referring Provider_____Contact person_____

Office phone_____ _____Office fax_____

LMP_____G___P___ EDD_____ Based on LMP or U/S_____

Date of Ultrasounds	Gestational age:	Date of Ultrasounds	Gestational age:
_____	_____	_____	_____
_____	_____	_____	_____

Service Requested

☐ Fetal Diagnosis Ultrasound and Consult

☐ One time consult in High Risk OB Clinic

☐ Transfer of Care to UI Hospitals and Clinics

☐ Share Care with UI Hospitals and Clinics Delivery

☐ Preconception and/or Genetic Counseling

☐ Maternal Serum Screening: ☐ 1st Trimester Only Screen ☐ Integrated Screen ☐ MaternitT21 Plus

Patient weight_____Race_____

Indication for Referral and Questions to be Answered

_____

_____

Fax the following information to 319-356-7556, if no reply in 48 hours call 319-356-2294

☐ Prenatal records ☐ Prenatal labs with blood type ☐All ultrasounds ☐ Maternal serum screening

☐ Subspecialty consultation notes (e.g. cardiology, endocrine, internal medicine)