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MUSC Health

REFERRAL

ADVANCED FETAL CARE CENTER REFERRAL REQUEST

Form Origination Date: 2/2020
Version: 1
Version Date: 2/2020

ADVANCED FETAL CARE CENTER

10 MCCLENNAN BANKS DRIVE
CHARLESTON, SC 29425
PHONE: 843.985.1084
FAX: 843.792.9373

PLEASE INCLUDE THE FOLLOWING TO FACILITATE SCHEDULING:

- ☐ Face sheet and/or Insurance Card
- ☐ Prenatal Care Records
- ☐ Lab reports
- ☐ Ultrasound reports
- ☐ Genetics

ADVANCED FETAL CARE CENTER REFERRAL REQUEST

☐ **Routine** ☐ **ASAP**

Patient Information

First Name:_____ **MI:**_____ **Last Name:** _____

DOB:___/___/____ **Contact Number:**_____ **Contact Number:** _____

Referring MD

First Name:_____ MI:_____ Last Name: _____

Office Phone:_____ Office Fax: _____

Primary OB/GYN

☐ Same as Referring

First Name:_____ MI:_____ Last Name: _____

Office Phone:_____ Office Fax: _____

EDC:____I__I____ ☐ **Singleton** ☐ **Multiples**

☐ Interpreter needed Language: _____

Indication for Referral: _____

Services requested:

☐ Comprehensive fetal evaluation as deemed necessary by MUSC Fetal Care Center

☐ Fetal ECHO/Fetal Cardiology. If delivery deemed necessary at MUSC, we will add a MFM consultation on the same day

☐ Other: _____

Consultation and imaging reports will be transmitted to your office as soon as possible. In addition to these reports, would you like to receive a phone call from the Consulting physician?

☐ Yes Phone Number: _____

Signature of Referring MD:_____ Date: _____

To refer a patient for Clinical Services, this form can be submitted electronically via the MUSC ADVANCED FETAL CARE CENTER website or submitted via Fax, to 843-792.9373.