Stanford Children's Health
Specialty Services – San Francisco

Fetal Echo Request Form

Attn: Referral Center
Tel (844) 733-2762 Fax (650) 725-7578

For urgent requests please call (844) 733-2762 option (2) and ask for on call pediatric cardiologist

Required Information

Provider Information

Referring Ob name: _____ _____ Fax: ( ) _____- _____
LAST FIRST

Referring MFM MD name: _____ _____ Fax: ( ) _____- _____
LAST FIRST

Patient Information

Date of referral: 2/6/2020 Week requested: _____ (generally rec 19–22 weeks)
MONTH / DAY / YEAR (ex. 1/31/2016)

Patient name: _____ _____ _____
LAST FIRST MIDDLE

Date of birth: _____
MONTH / DAY / YEAR (ex. 1/31/2016)

Current estimated weeks of gestation: _____

Due date: _____
MONTH / DAY / YEAR (ex. 1/31/2016)

Twin gestation: ◯ Yes ◯ No

Reason for referral /indication:

Locations

San Francisco
1100 Van Ness Ave., 7th Floor
San Francisco, CA 94109

San Mateo – Mills Health Center
Women's Center
100 S. San Mateo Dr., 4th floor
San Mateo, CA 94401

Novato
101 Rowland Way, Suite 220
Novato, CA 94945

Santa Rosa – Pediatric Cardiology
990 Sonoma Ave., Suite 9
Santa Rosa, CA 95404

Please provide relevant medical records (needed for patient care and authorization)