Please specify the priority of your request:
- Urgent
- ASAP
- Routine, please schedule for ________ weeks GA

This is for a:
- Singleton
- Multiple Gestation: Twin, Triplet

Obstetrical History:
EDC: ______________
Gestational age today _______ wks _______ days
G____P______TAB______SAB_______IUFD ______

Genetic Screening or Testing:
- Prenatal Screening __________________________
- Cell free fetal DNA/NIPT ______________________
- Amniocentesis/CVS ___________________________

Indications for Referral:
- Suspected cardiac abnormality:
  - Increased Nuchal Translucency, NT: _______ mm
  - Fetal Cardiac Arrhythmia
  - Extra cardiac anomaly:
  - Known or suspected chromosomal abnormality:
  - Maternal diabetes: Type 2 ______ Type 1 ________
    GDM(HbA1c>6%) __________________
  - Assisted reproductive technology, IVF
  - Family history of CHD. Please provide details if available:
  - Maternal SSA+/SSB+ autoantibodies (Lupus, Sjogrens Syndrome). Please include labs if possible.
  - Exposure to maternal medication or teratogenic substance:
  - Monochorionic twinning
  - Other: ________________________________

Referral
Assume present and future (if needed) management of this patient, restricted to area of fetal cardiology. Patient will return to OB/MFM Office for all other aspects of care. Ongoing cardiology evaluation (when needed) will be ordered by fetal cardiologist.

Consultation (one visit)
- With fetal echocardiogram
- Without fetal echocardiogram

Patient will return to OB/MFM Office for all aspects of care, and future cardiology consultations will require new request.

Referring Physician Contact Information:
______________________________________________________________
Phone __________________________
Fax __________________________

Please cc/send additional report to:
______________________________________________________________
Phone __________________________
Fax __________________________