Lucile Salter Packard Children's Hospital
STANFORD UNIVERSITY MEDICAL CENTER
725 Welch Road Palo Alto, CA 94304

Medical Record Number

Patient Name

ORDERS • FETAL ECHOCARDIOGRAM

Addressograph or Label – Patient Name, Medical Record Number

Physician: Check all orders that pertain to the patient. Date, time & sign all orders.

Lucile Packard Children's Hospital at Stanford

REFERRAL FORM

FETAL CARDIOLOGY PROGRAM

Daniel Murphy, M.D. Norman Silverman, M.D.
Inger Olson, M.D. Theresa Tacy, M.D.
Rajesh Punn, M.D. Christopher Talluto, M.D.

Phone (650) 721-2121 Fax (650) 497-8422

Date of request: _____

Consultation requested for gestational age _____ weeks

Patient contact information: _____

_____

_____

_____

Date of birth: _____ Age _____

Obstetrical History:

G _____ **P** _____**TAB** ____ **SAB** ____ **IUFD** _____

Gestational age today _____ Weeks

Indication for consultation:

Fetal_____

_____

Maternal _____

_____

Familial _____

_____

Diagnostic Information

Amnio

Yes _____ Date _____ No _____

Results _____

Maternal Serum Screen

Results _____

Primary Physician (OB)

_____

_____

Address _____

Phone _____

Fax _____

Other Consulting Physician

(If being referred by MFM/Geneticist/Radiologist)

_____

_____

Address _____

Phone _____

Fax _____

Other Services to Be Contacted

_____

_____

_____

Requesting Physician

Printed Name: _____

Signature: _____

**If your patient's insurance requires preauthorization, please contact them for authorization with confirmation faxed or sent to this department

Fetal Echo Codes 76825, 76827, 99325 **AND Consultation Code** 99241-99245 **(Both required)**

FOR LPCH HC STAFF ONLY
DATE OF SCHEDULED FETAL ECHO _____
GESTATION AT SCHEDULE DATE _____
REVIEWED BY _____ DATE _____
COMMENTS _____

L14020.02.10