Comprehensive Prenatal Screening Program
Physician Referral Form

1901 Outlet Center Dr. Suite 120 • Oxnard CA 93036
Tel: 805.604.9500 • Fax: 805.604.9559
www.PalmsImaging.com

PATIENT INFORMATION

Name (Last/First/MI): ______________________ /__________________/______ DOB: _____/_____/______

Phone (Home): ____________________________ Work: ___________________ Cell: ___________________

Appointment Date: ________________________ Appointment Time: __________ ☐ Spanish Speaking

Special Instructions/Needs: ____

INDICATION(S) FOR REFERRAL

____

____

____

SCREENING VISIT OPTIONS:

☐ First Trimester Screen w/ blood draw, NT U/S
☐ OB <14 Weeks with Transvaginal
  ☐ If within range, perform NT U/S
☐ NT Only

☐ Second Trimester Blood Draw
☐ OB >14 Weeks (Please give indication): ______________________________
☐ OB Follow-up

☐ Limited U/S for AFI, Fetal Position, Fetal Weight, Other: ______________
☐ Biophysical Profile
☐ Umbilical Artery and MCA Doppler

ADDITIONAL INFORMATION (REQUIRED)

☐ PLEASE PROVIDE F #: ____
☐ PATIENT HAS ALREADY HAD BLOOD WORK DONE ON: _______________________________
☐ PATIENT IS TO BE SENT BACK TO YOUR OFFICE TO HAVE THEIR BLOOD WORK DONE

☐ Additional Relevant Patient Information (FAX copy of Labs, U/S Reports, HNP, Progress Notes)
  ☐ Dating: by LMP _____________ or U/S on _____________ at __________ w__________ d
  ☐ Prior U/S ☐ U/S Results ____

REFERRING PHYSICIAN INFORMATION

Contact Person: _______________________ Phone: ____________________ Today's Date: ____________

Address/City/Zip: ____ Fax: ____________________

Referring MD (Print): __________________________________ Signature: __________________________

PLEASE BRING A COPY OF THIS FORM TO YOUR APPOINTMENT