Kalispell, Origin Health Maternal Fetal Care

Please send this completed order form with appropriate documentation – demographics, insurance, pertinent prenatal records, any relevant ultrasound or operation reports, pregnancy flow sheet, and pertinent labs (including 1st trimester, quad screen, NIPS results) to **Fax: (855) 877-6894.** Office phone: (406) 751-3003.

Once we receive this information, we will contact your patient and set up an appointment.

Name:_____ DOB: _____ SSN:_____

Address: _____

Home phone: _____ Mobile phone: _____ Email: _____

Insurance: Self Pay MT Medicaid Other _____

Group No. _____ Policy No. _____

Dating: EDD: _____ LMP: _____

Dating Method: Unknown LMP 6-12 wk US Other US IVF/ET Known conception

Clinical Information for Referral/Consultation/Procedure(s) Requested:

_____

_____

Service(s) Ordered/Requested:

MFM OB **ultrasound** evaluation (trans abd and/or vaginal, w/ indicated consult, follow-up, & tests of fetal wellbeing)

Dates/Viability Dates/Anatomy Fetal Echo FU Growtih/Anat Cx Length APT (BPP/indicated Dopplers

MFM **consultation** with indicated ultrasound procedure(s) (e.g. medical, surgical, genetic. Obstetrical problems, etc.)

Currently Pregnant Recently Postpartum Preconception

GYN/REI ultrasound

Follicle Scan Endometrium GYN/pelvis complete Sonohysterogram Other (specify): _____

This evaluation is:

Urgent **or** Routine (timed as clinically indicated)

Timed if possible (e.g. scheduled before a future visit). Date/Time of the future visit: _____

Preferred location of service: Butte Great Falls Hamilton Helena Kalispell Missoula Ronan

Ordering Provider Name _____ Signature _____ Date/Time _____