Perinatal SPECIALISTS OF KANSAS CITY

• STANDARD REFERRAL •

16240 Foster St. Stilwell, KS 66085
1300 NE Windsor Dr. Lee's Summit, MO 64086
p 913.291.0069 • f 913.291.0070

Patient Name: _____ DOB: _____

Contact #: _____/_____ Social Security #: _____

Insurance: _____ Appt. Date: _____@_____

Blood Type: _____G:_____P:_____ ***IF ALREADY SCHEDULED***

Gestational number: Singleton / Twins / Triplets

LMP: _____ Indicate chorionicity: _____

EDC by LMP_____EDC by US:_____ Final EDC:_____

*****PLEASE NOTE:*** **If a referral or pre-authorization number is required, we CANNOT make an appointment until received.**

REASON FOR VISIT: _____

PLEASE MARK ALL TESTS REQUIRED:***

_____Perinatal consult with ultrasound (including ultrasound type as clinically indicated)
_____Preconception consult
_____Genetic consult (please indicate specific condition)
_____Diabetic education only (Will not have history reviewed with physician. Patient cost $30)
_____Fetal echocardiogram
_____First trimester ultrasound / nuchal translucency
_____Other testing (specify):_____
_____Interpreter needed: Y / N Language:_____

****Please FAX *All* Items listed below – patient cannot be seen without these records****	
O	Completed Referral Form
O	Copy of Patient Insurance Card
O	Current Lab Reports
O	*Any* Ultrasound Reports for This Pregnancy
O	*Any* Genetic Results
O	OB Visit Summary
O	*Any* Testing or Reports Related to Condition Affecting Pregnancy

Referring Facility/Provider Information

Facility:_____Phone:_____Fax:_____

Provider:_____Office Contact:_____

Ordering Provider Signature:_____Date:_____

Please fax all records, including a copy of the patient's insurance card, after you have called for an appointment

Thank you!
We appreciate the opportunity to partner with you in your patients care!