• SCAN-ONLY REFERRAL •

Dating, viability, growth, BPP, or anatomy scan-only

16240 Foster St. 1300 NE Windsor Dr.
Stilwell, KS 66085 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.*

THIS FORM IS FOR USE WHEN CONSULTATION IS NOT REQUESTED. A PHYSICIAN VISIT OR OPINION ASIDE FROM READING THE ULTRASOUND WILL NOT OCCUR UNLESS AN ULTRASOUND ISSUE IS IDENTIFIED.

IF WE HAVE NOT SCANNED PATIENT IN CURRENT PREGNANCY A BPP WILL INCLUDE A BASIC ANATOMY

REASON FOR VISIT: _____

PLEASE MARK ALL TESTS REQUIRED:***

_____Anatomy ultrasound with reflex consultation, if indicated
_____Dating ultrasound with reflex consultation, if indicated
_____Viability scan with reflex consultation, if indicated
_____Diabetic Education Only (Will not have history reviewed with physician. Patient cost $30)

****All ultrasound testing will reflex to a perinatal consult as clinically appropriate****

_____Interpreter Needed: 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	Any Genetic Screening Results
O	*Any* Ultrasound Reports for This Pregnancy
O	*Any* Genetic Results

COMPLETE OB RECORDS ARE NOT NEEDED IF A CONSULT IS NOT REQUESTED

Referring Facility/Provider Information:

Facility:_____Phone:_____Fax:_____

Provider:_____Office Contact:_____

Ordering Provider Signature:_____Date:_____

Thank you!

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