Perinatal Specialists of Kansas City
16240 Foster Street
Overland Park, KS 66085
(ph) 913.291.0069 • (fax) 913.291.0070

Patient Name: _____ DOB: _____

Contact #: _____/_____ Social Security #: _____

Insurance: _____ Appt. Date: _____@_____

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

Number of Gestations: 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):_____

***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	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

We appreciate your referrals!