CONSULT WORKSHEET

Date: ________________ **Gestational Age (at time of referral):** ______________ weeks

Please check preferred Location

Peachtree _______
Riverdale _______
Stockbridge _______
Decatur _______
Conyers _______
Newnan _______

**** Please email referral to: Referral@atlantaperinatal.com ****
If phone call or fax is preferred, please contact us at: (770) 471-7402 / Fax: (404) 872-3119

Urgency of Referral: ☐ **Routine** (seen within 2-4 weeks) ☐ **Urgent** (seen within 1 week) ☐ **Emergent** (48 hrs)

Patient Information:

Patient Name: ______________________________
Patient ID (if applicable): _____________________
Address: ___________________________________
City: _______________________ **State**: _______
Email Address: ______________________________
Date of Birth: _____________________
Phone Number: _____________________
Cell Number: ______________________
Zip Code: _________________________
Preferred Language: ________________

Referring Provider Information:

Referring Provider Name: __________________
Phone Number: ___________________________
Email Address: ___________________________
City: ___________________ **State**: __________
Practice Name: _____________________________
Fax Number: _____________________________
Office Address: ____________________________
Zip Code: __________________________________

Insurance Information:

Primary Insurance: ___________________________
Group Number: ______________________________
Subscriber DOB: _____________________________
Policy Number: ______________________________
Subscriber Name: ____________________________
Insurance Phone Number: _____________________

Reason for Referral:

☐ **Hypertension** ☐ **PIH** ☐ **Diabetes** ☐ **GDM** ☐ **Abnormal Ultrasound**
☐ **IUGR** ☐ **PTL** ☐ **Multiple Gestation** ☐ **Incompetent Cx** ☐ **IUFD Hx/Miscarriage Hx**
☐ **Advanced Maternal Age (AMA)** ☐ **Pre-eclampsia** ☐ **Abnormal Test Result** ☐ **Anatomy/Dating**
☐ **Fetal Anomaly** ☐ **PACs or Other Fetal Arrhythmia** ☐ **History of Pregnancy Complications**
☐ **Other**:
____

Services Requested (check all that apply):

☐ **Perinatal Consultation** ☐ **Level II Ultrasound** ☐ **Fetal Echocardiogram**
☐ **Non-Stress Test (NST)** ☐ **Biophysical Profile (BPP)** ☐ **Genetic Counseling**
☐ **Diabetes Education** ☐ **Amniocentesis** ☐ **Other**: __________________________

Previous Test Results (if applicable):

☐ **Ultrasound**
Date: ________ Findings: _____________________
☐ **Blood Tests**
Date: ______________ Results: ________________
☐ **Genetic Testing**
Date: ________ Results: _____________________
☐ **Other Tests**
Type: ______________ Date: _________ Results: __________

Internal Use Only

Scheduled Appointment Date: ______________ **Scheduled Appointment Time: ____________**

*****A Perinatal Consultation will be provided to abnormal findings as indicated*****