PageMed
HEALTHCARE WITHOUT BORDERS

AN ATLANTA PERINATAL ASSOCITAES COMPANY

REFERRAL FORM

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

Please check preferred Location

Peachtree	_____	**Decatur**	_____
Riverdale	_____	**Conyers**	_____
Stockbridge	_____	**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: _____ **Date of Birth**: _____
Patient ID (if applicable): _____ **Phone Number**: _____
Address: _____ **Cell Number:** _____
City: _____ **State**: _____ **Zip Code**: _____
Email Address: _____ **Preferred Language**: _____

Referring Provider Information:

Referring Provider Name: _____ **Practice Name**: _____
Phone Number: _____ **Fax Number**: _____
Email Address: _____ **Office Address**: _____
City: _____ **State**: _____ **Zip Code**: _____

Insurance Information:

Primary Insurance: _____ **Policy Number**: _____
Group Number: _____ **Subscriber Name**: _____
Subscriber DOB: _____ **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 Time: _____**

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