Legacy Medical Group - Maternal Fetal Medicine
Referral Form

☐ **Emanuel Campus**
300 N. Graham Street, Suite 100
Portland, OR 97227
Phone: 503- 413- 1122
Facsimile: 503- 413- 4238

☐ **Tuality Campus**
364 SE 8th Ave, Suite 200
Hillsboro, OR 97123
Phone: 503-413-3399
Facsimile: 503-413-4238

☐ **Salmon Creek Campus**
2101 N.E. 139th Street, Suite 260
Vancouver, WA 98686
Phone: 360-487-2870
Facsimile: 360-487-2879

Toll Free : 800-335-2229

Date: _____

Patient's Name:		**Patient's Home Number:**	
Patient's D.O.B:	**Social Sec: #**	**Patient's Home Address:**	
Referring Physician/Provider:		**Referring Physician's Address:**	
Referring Physician's Phone:		**Referring Physician's Facsimile:**	
Referring Physician's Signature:		**Interpreter Required:** ☐ **Yes** ☐ **No** **If Yes - What Language:**	

Primary Insurance:	**Phone:**	**Secondary Insurance:**	**Phone:**
Subscribers Name:	**Date of Birth:**	**Subscribers Name:**	**Date of Birth:**
Policy Number/ Group #:		**Policy Number / Group #:**	

LMP:	**EDC:**	**Blood Type:**	**G:**	**P:**	**A:**

REASON FOR REFERRAL / DIAGNOSIS:

☐ **MFM/ Perinatal Consult (may include u/s if indicated)**

☐ **Prepregnancy MFM Consult**

☐ **Prepregnancy Genetic Consult**

☐ **NST/ AFI or BPP**

Please contact me about :
☐ **Share Care** ☐ **Assume care**

Has the patient had Genetic Counseling before:
☐ **Yes** ☐ **No**

If Yes When and Where:

☐ **Ultrasound (w/ Genetic Counseling or MFM Consult if indicated)**

☐ **Check Viability or Cervical Length or Dating**

☐ **1st Trimester Screen (with Genetic Counseling if > 35 yrs. Old)**

☐ **Chorionic Villus Sampling (CVS) or Amnio w/ Genetic Counseling**

Working EDD __/__/_____ based on _____

Working Gestational Age: _____

Previous US performed @ _____ on __/__/_____

Office Use Only: