

# Pregnancy Notification (First Prenatal Visit)



**Please send fax to 702-691-5620  
(Must be faxed within 15 days of first visit)**

Type of Referral:

☐ Pregnancy Notification    ☐ High Risk Pregnancy    ☐ Miscarriage/Termination Notification

Member ID #: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City/State: \_\_\_\_\_

Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

EDD: \_\_\_\_\_ Gestational Age (GA): \_\_\_\_\_

Physician: \_\_\_\_\_

Street Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Tax ID #: \_\_\_\_\_

The information contained in this facsimile is confidential and includes protected patient health information. The information is intended only for the use of CHF and its designees.

If you are not the intended recipient or the employee or the agent responsible to deliver it to the intended recipient, you are hereby notified that any use, disclosure, distribution or copying of this communication is strictly prohibited. If you have received this facsimile in error, please immediately notify us by telephone at (702) 892-7393 and return the original message to us at CHF, 1901 Las Vegas Blvd South Suite 101 Las Vegas, NV 89104.

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