Maternal-Fetal Medicine Referral Form

902 McCallie Avenue • Chattanooga, TN 37403
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1-800-HI-RISK
www.rocob.com

Circle ALL indications that apply

First Trimester Screen

Anatomy Scan

Chronic Hypertension

Morbidly obese

Multiple Gestations

Med Evaluation: specify
____

Fetal Anomaly: specify
____
____

Previous PTL/Delivery

AMA
Already had NIPT*? ___yes ____no

Abnormal Screening
First trimester?______
Quad/AFP?_________
NIPT*?_______

Genetic Disorder-specify
____
____

Multiple Miscarriages

Diabetes
Gestational______
PCOS/insulin res____
Pre-existing:
Type1___ Type 2___

Other ____________
____
____

Therapist

Fill out completely and fax to ROC with patient records

Patient Information

Name: ________________________ DOB: _______________ SSN:_________________

Address: ____

____

Preferred Phone Number: ____________________________________

Emergency Name/Number: ____

Referring OB Name/Number: ______________________________ Fax:_________________

PATIENT'S EDD: ____________________

We will contact the patient with their appointment information.

Insurance Information

Primary: ____________________ ID/Group Number:_____________________

Secondary: ___________________ ID/Group Number:_____________________

Tertiary: _____________________ ID/Group Number: ____________________

Referral/Auth (if necessary): ____

Referring provider is responsible for initiating referrals/authorizations for visits.

PLEASE FAX ALL RECORDS, DEMOGRAPHICS AND COPY OF INSURANCE CARD(S) WITH REFERRAL FORM!!

ROC- In Office Use Only

Appt Date: ______________________ **Appt Time**: __________________________

Appt Location: Chattanooga Cartersville Cookeville Cleveland

Calhoun Rome Blairsville Dalton McMinnville Winchester Crossville

Appt Confirmation Date/Name: ____

**NIPT=cell free DNA (MaterniT21, Panorama, Harmony, InformaSeq, Verifi)*