# New Patient Referral/ Physician Order for BCH FCSC

Boston Children's Hospital
Fetal Care & Surgery Center
bostonchildrens.org/fcsc
617-355-6512 | *fax* 617-730-0124
FCSCReferrals@childrens.harvard.edu

Please **fill out all fields** and ensure that the form is **signed and dated by the ordering clinician**.

Submit the completed form via fax or email. **Fax: 617-730-0124**
**Email: FCSCReferrals@childrens.harvard.edu**

For all questions, call the Fetal Care and Surgery Center: **617-355-6512**.

## Patient information

First name: _____

Last name: _____

Date of birth: _____ Gender: ❍ M ❍ F ❍ Other: _____

Address: _____

City: _____ State/Province/Region: _____

Zip/Postal code: _____ Country: _____

Phone: _____ ❍ Cell ❍ Home ❍ Office ❍ Other

Email: _____

Preferred language: _____ Interpreter needed? ❍ Yes ❍ No

Indication/Diagnosis: _____

Current anticipated delivery location: _____

Prior care for pregnancy or child at Boston Children's? ❍ Yes ❍ No

EDC:_____ Due date: _____

❍ Singleton ❍ Twins ❍ Other: _____

## Insurance information

PCP (required for insurance): _____

Insurance company: _____

Plan name: _____

Insurance ID number: _____

## Referring physician information

**Physician name:** _____

Practice name: _____

Address: _____

City: _____ State/Province/Region: _____

Zip/Postal code: _____ Country: _____

Phone: _____ Fax: _____

Email: _____

Physician specialty: ❑ OB ❑ MFM ❑ Cardiologist ❑ Other

**Primary OB** (if different)**:** _____

Practice name: _____

Address: _____

City: _____ State/Province/Region: _____

Zip/Postal code: _____ Country: _____

Phone: _____ Fax: _____

Email: _____

## Requested appointments/Physician order:

❑ Fetal Echo ❑ Fetal MRI ❑ Fetal Ultrasound ❑ MFM Consult

❑ Consult: _____

❑ Consult: _____

❑ Other (please specify): _____

❑ **Fetal Intervention**

## Items to include:

❑ Demographic sheet with Insurance Information
❑ ALL records and imaging reports from this pregnancy
❑ Lab work, genetic testing, amnio results
❑ Prenatal early screening results
❑ CD of images (if applicable)

## Requested timeframe schedule:

_____

_____

_____

_____

Please understand that appointments will be scheduled based on availability, as well as triaged clinical severity.

## Ordering clinician

❑ **CHECK THIS BOX** to refer to Boston Children's Hospital Fetal Care and Surgery Center for evaluation and treatment including diagnostic testing.

Name: _____

Signature: _____

Date: _____