UC DAVIS HEALTH | CHILDREN'S HOSPITAL

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fetalcare.ucdavis.edu

Fetal Care and Treatment Center (FCTC) Referral

Please complete, print and fax this form to **(916) 734-4452**. Call **(916) 794-BABY** with any questions.

- Additional prenatal diagnostic testing may be ordered as clinically indicated.
- Referral to the FCTC allows for comprehensive fetal evaluation and provision of care as assessed by the FCTC.

Referral Indication/Fetal Anomaly: _____

Patient name: _____ Phone number: _____

Date of birth: _____ LMP: _____ EDD: _____

G: _____ P: _____ Current gestational age: _____

Translator needed? No ____ Yes____ (language): _____

Referring provider name: _____

Office phone: _____ Office fax: _____

Office address: _____

Primary OB (if not referring provider): _____

Services requested:

☐ Fetal Ultrasound

☐ Fetal ECHO/Cardiology

☐ Fetal MRI
Patient weight _____ *Needed to complete MRI

☐ Fetal Intervention/Surgery

☐ Maternal Fetal Medicine

☐ Prenatal Genetic Counseling

☐ Pediatric Surgery

☐ Prenatal consult with subspeciality: _____
_____

☐ Other: _____

Please fax the following information to (916) 734-4452:

- Insurance information (front and back of card)
- Patient Demographic Sheet
- Obstetrical records for current pregnancy including:
  - Prenatal record with medical and pregnancy history
  - Ultrasound Reports
  - Prenatal labs
- State Screening/Prenatal Screening Testing
- NIPS (Harmony, MaterniT 21, Panorama)
- Amniocentesis/CVS results (karyotype/microarray)