FETAL ECHO and CONSULT ORDER FORM

FAX form to 513-636-9747

3333 Burnet Ave., MLC 9014
Cincinnati, OH 45229-3039
Forms: www.cincinnatichildrens.org/consults

CCHMC MRN (Internal use only): _____

Please fill out completely. Always provide demographics/language/insurance.

Patient's Name: _____ Date of Birth: _____/_____/_____

Phone: ( ) _____-_____ Alt Phone: ( ) _____-_____

Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

Height: _____ Weight: _____ ☐ lbs ☐ kilos BMI: _____

Date of this request: _____/_____/_____ Gestational age at time of this request: _____ weeks

Number of fetuses: _____ Estimated Due Date: _____/_____/_____

☐ Suspected heart defect
☐ 2 Vessel Cord (2VC)
☐ Chronic Hypertension (CHTN)
☐ Cleft lip/Absent nasal bone
☐ Invitro fertilization (IVF)
☐ Drug exposure
☐ Delivery planning
☐ Cystic Hygroma
☐ Size discrepancy
☐ Sjogren's/SSA/SSB antibodies
☐ Diabetes
☐ Family History/Parent or Sibling
☐ Arrhythmia/PACs
☐ Pericardial Effusion
☐ Twin/Triplet pregnancy
☐ Abnormal genetic findings
☐ Advanced Maternal Age (AMA)
☐ Other: _____

Complications: _____

_____

☐ MFM ☐ OB/GYN ☐ Cardiologist Prior Authorization Confirmation Number: _____

Ordering Practitioner: _____ Group Name: _____

Office Address: _____

Office Phone: ( ) _____-_____ Office Fax: ( ) _____-_____

Signature/Credentials of Ordering Practitioner: _____ Date: _____ Time: _____

If Abnormal – follow up contact name: DR. _____ Phone: ( ) _____-_____

Secondary Office (If applicable): **All information must be completed, accurate & HIPAA compliant**

Group Name: _____

Address: _____ Fax: ( ) _____-_____

For assistance, please call 513-636-9931

DTA0123