Cincinnati Fetal Center

Patient Referral Form

Referral Guidelines

To our referring physicians,

To be cognizant of our patients' financial well-being, we are asking all referring physicians to complete the information below for each patient referred to Cincinnati Fetal Center. Given the often emergent nature of the referral to our center, this form will allow faster pre-authorization for insurance coverage. Please note this form allows for pre-authorization at Cincinnati Children's Hospital. Our partnering institutions will pre-authorize for any medical performed within their institution.

We appreciate your help in this important matter! Please let us know if you have any questions as you complete the form.

Please send the following for review as soon as possible to cfcreferral@cchmc.org or fax to 513-636-5959:

1. Completed referral form
2. Copy of front and back of insurance card(s)
3. Patient's OB cart, including progress notes and a demographics sheet
4. All imaging reports from patient's current pregnancy
5. All lab reports including blood type, TORCH, and genetics labs as applicable

Referring Physician Office Information

Referring Doctor: _____ Phone number: _____

Office address: _____ Fax number: _____

City, State, Zip: _____ NPI: _____

Patient Information

Patient Name: _____

Home address: _____

City, State, Zip: _____

Best contact phone number: Home: _____ Cell: _____ Work: _____

Suspected diagnosis: _____

Estimated gestational age: _____ Estimated due date: _____

If outside of OH, KY, IN: please advise why patient must be seen at Cincinnati Fetal Center specifically:

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