



Cincinnati Children's Fetal Care Center Referral Form

Patient Name: _____ DOB: _____

Cell Phone: _____ Other Phone: _____

Insurance Carrier: _____ Policy ID: _____

Reason for Referral: _____

Current Gestational Age: _____ EDD: _____

Date and Location of Last Ultrasound: _____

**Please send the following to
cfcreferral@cchmc.org or fax to (513) 636-5959**

Ultrasound Reports	ACOG Prenatal Chart	Progress Notes	Labs/ Genetics
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Referring Physician: _____ Contact number: _____

Facility Name: _____ Phone: _____ Fax: _____

Additional Information: _____

Once referral is received, the patient will be contacted within 1 business day.

Pediatric Surgery

Foong-Yen Lim, MD, FACS, FAAP
Surgical Director

Jose L. Peiro, MD, MBA
Director Endoscopic Fetal Surgery

Beth Rymeski, DO
Pediatric Surgeon

Neonatology

Stefanie Riddle, MD
Neonatal Director

TriHealth

Mounira Habli, MD
Maternal-Fetal Medicine Specialist

Mallory Hoffman, MD
Maternal-Fetal Medicine Specialist

University of Cincinnati

Braxton Forde, MD
Maternal-Fetal Medicine Specialist

David McKinney, MD
Maternal-Fetal Medicine Specialist

Kara Markham, MD
Maternal-Fetal Medicine Specialist

Patient Services

Kim Burton, MSN, MBA, RNC-NIC
Clinical Director

Angela Ervin, BSN, RN, CSN
Clinical Manger

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