OBGYN ULTRASOUND OF PUGET SOUND | pediatrix

p: 206-400-7625 | f: 206-274-4881

PATIENT REFERRAL

Please fax ALL records and registration information with referral

Date: ________________ Referred by: ____________________________________Fax No.: ____________________

First Name: _________________________ Last Name: _________________________ DOB: ___________________

Home No.: ______________________________ Alternate No.: ____

Interpreter needed (specify language): ____

EDD: ______________ **Diagnosis:** ____

OBSTETRIC EXAMS (WITH consult if abnormal)

FIRST TRIMESTER (with TV exam if indicated):

☐**Size and dates/viability** (Number of gestational sacs/fetuses, crown rump length, maternal UT and adnexa)

☐**First trimester anatomy** (12w0d-13w6d, includes size and date images and visible anatomy)

☐**Nuchal Translucency** (12w0d-13w6d)

SECOND/THIRD TRIMESTER (with UA/MCA doppler if indicated; TV exam if indicated):

☐**Limited** (one or more: fetal position, heartbeat, placental location, AFI)

☐**TV cervix** (transvaginal evaluation of the cervix)

☐**Marker study** (16-18 weeks)

☐**Detailed exam** (20w0d)

☐**Follow-up (circle one): Growth/anatomy**

☐**Complete** (assessment of growth and anatomy)

☐**Fetal echo** (22-24 weeks, only if prior anatomy US performed by MFM)

☐ **Biophysical profile (BPP)**

Pelvis (Non-OB)

☐**Pelvis complete** (includes transabdominal and transvaginal exam)

☐**Transvaginal** (short-term follow-up of previous abnormalities on pelvis exam, days five through nine of menses if evaluation for endometrial pathology)

☐**Pelvis** (transabdominal only, no TV exam)