Prenatal Referral

Palmetto Health USC
OBSTETRICS AND GYNECOLOGY

Date _____

Fax referral and records to **803-434-7756**
For questions call **803-545-5700**

Referring Practitioner _____ Contact _____

Phone _____ Fax _____

Patient Information

Name _____

Date of birth _____ Social Security Number _____

Address _____

City/State/ZIP _____

Primary contact number _____ Secondary contact number _____

Does patient speak English? ☐ Yes ☐ No If no, what language? _____

Insurance Information

☐ Private insurance (type) _____ ☐ Self-pay _____

Medicaid: ☐ Fee for service ☐ HMO (please specify) _____

Preauthorization # _____

Name of insured _____ Relationship to insured _____

Required

Requested service: (check as many as needed) ☐ Consultation: ○ MFM Physician ○ Genetics

☐ Maternal fetal medicine OB transfer of care ☐ Ultrasound _____

☐ Diagnostic Testing: ○ CVS ○ Amniocentesis

We will provide additional clinical services deemed necessary at time of visit. If you do not wish that, please specify below:
☐ Provide only what is ordered

Reason for requested service(s) as checked above *(as much information as possible)* _____

_____

To schedule clinical services, please fax all items listed below. Appointment will not be scheduled until records are received.
- Prenatal records
- First Trimester/quad screen results/genetic screens
- Prenatal lab reports (original reports)
- Prior pregnancy dating ultrasound reports

LMP__ /__ /___ Final EDC __ /__ /__ Dated by: ☐ US ☐ LMP

Patient's weight _____ lbs Blood type _____ ☐ Singleton ☐ Multiples

_____ _____
Signature of referring physician Date

Please inform your patient that children are not allowed in our ultrasound suites and may not sit unattended in the waiting room.

2 Medical Park Rd.
Suite 106
Columbia, SC 29203
803-545-5775 phone
803-434-4596 fax

PHUSCMG.org