SHORE MEDICAL CENTER

Maternal Fetal Medicine
155 Medical Center Way
Somers Point, NJ 08244
609-653-3636 Fax 653-3863

REQUEST FOR ANTEPARTUM STUDIES

Name_____ **Referring Physician**_____
DOB_____EDD_____ Has patient been seen by Dr. Debbs in past
LMP_____G___P_____ _____
Office staff Making Request_____

TEST REQUESTED

___Ultrasound (send any prior U/S reports)
___Fetal Echocardiography
___Perinatal Consult
___Antenatal Testing;
___NST___AFV___BPP
___Genetic Counseling
___NIPT Testing
___Amniocentesis
___CVS
___Pre-pregnancy Consult

INDICATIONS FOR EVALUATION

___Gestational Dating
___Size less than dates R/O IUGR
___Size greater than dates R/O Macrosomia
___Anatomical Survey
___Suspect Fetal Anomaly
___AMA
___Abnormal Screen
___H/O Genetic/Anatomic Anomaly
___Maternal Drug Exposure
___Threatened AB
___R/O Ectopic Pregnancy
___Hyperemesis
___Adenexal Mass
___Post Dates
___Previous H/O Pregnancy Complication
___Recurrent Pregnancy Loss
___Diabetes
___Gestational diabetes
___Hypertension Chronic/gestational
___Medical Complication
___Isoimmunization (type)_____
___Fetal Arrhythmia
___Multiple Gestation
___Incompetent Cervix
___Placenta Previa
___Vaginal Bleeding
___Malpresentation
___Decreased Fetal Movement
___Other **specify** below

Comments_____
_____

Physician
Signature_____

For MFM office use
Appt Date/Time_____ Spoke to_____