Request For Services for Maternal Fetal Medicine
Pan Am: 1600 Kapiolani Blvd, Suite 1025 Honolulu, HI 96814
Queen's West POB: 91-2139 Fort Weaver Rd, Suite 311 Ewa Beach, HI 96706
Phone: 808-945-2229 Fax: 808-945-2230

Date of Request: _____

Patient Name:_____ **Date of Birth: _____**

Patient Contact Phone #: _____ **LMP: _____ EDC: _____**

HT: _____ Wt: (pre-pregnancy) _____

INSURANCE INFORMATION:

Subscriber Name: _____ **Relationship _____ DOB: _____**

Insurance Type: _____ **Subscriber ID: _____**

INTERPRETER REQUESTED: YES_____ NO_____ **Language: _____**

If MFM recommends additional testing, do you want FDIP to order and schedule the service? YES___ NO ___

Services Requested:

__ Amniocentesis Genetic
__ Chorionic Villus Sampling
__ Sonohysterogram
__ Gynecologic Ultrasound
__ Cervical Length
__ First Trimester Ultrasound (Nuchal)
__ 2nd Trimester Ultrasound (Detailed ultrasound)
__ 3rd Trimester Ultrasound
__ Fetal Echocardiogram
__ Antepartum Fetal Testing (NST/AFI)
__ BPP only
__ MFM Consultation Only
__ MFM Consultation & Co-Management
__ Genetic Counseling

FDIP SWEET SUCCESS:
__ Diabetes in pregnancy
__ MFM consultation

Clinical Indications:

__Abdominal Pelvic Pain
__ Bleeding
__ Amenorrhea
__ Menorrhagia
__ Cervical Incompetence
__ Abortion missed/threatened.
__ Ectopic pregnancy
__ Late Prenatal Care
__ Fetal Drug Exposure
__ Fetal heart rate/ rhythm abnormal
__ Abnormal screen (NIPS/Serum)
__ Ovarian Cysts
__ Fibroids
__ Decreased fetal activity.
__ Small for dates (IUGR)
__ Large for dates
__ History of previous pregnancy complication
__ Placenta Low Lying
__ Oligohydramnios
__ Polyhydramnios

__ Advanced Maternal Age
__ Primi __Multi
__ Fetal Anatomy
__ Hypertension gestational
__ Hypertension pre-existing
__ IVF pregnancy:
Donor Egg: __yes __no
Age of Donor egg: _____
__ Multiple gestation
__ Twins __Triplets
__ Diabetes Mellitus, pregestational (Type 1 or 2)
__ Diabetes Mellitus, Gestational
__ High BMI
__ Other Indications:
_____
_____

Appointment information:

Scheduled Date/Time: _____ Pan Am ___ Queens West ___ Maui ___ Kauai___ Hilo ____

Requesting Provider Name: _____

Contact Person: _____ Phone: _____ Fax: _____

Provider Signature: _____