BEVERLY FAX 626-571-1200 OR (909) 622-8047

SAN GABRIEL VALLEY PERINATAL MEDICAL GROUP, INC.

APPOINTMENT INTAKE INFORMATION SHEET

Today's Date_____

Last Name: _____ First Name: _____

Address _____City _____ Zip _____

Primary Phone Number (_____)_____ Secondary Number (_____)_____

DOB: _____ Age _____ Language: _____ Social Security # _____

Insurance _____ID# _____

Referring M.D. _____ Signature of M.D. _____

Address _____City _____ Zip _____

Phone (_____)_____ Fax (_____)_____Contact _____

Gravida: _____ Para: _____ LMP: _____ EDC: _____ (U/S Done on: _____; GA @ U/S: _____)

Please fax a copy of patient's insurance card, signed patient information sheet, prenatal records, ultrasounds, AFP results (front and back), pertinent laboratory results and all supporting documentation for your diagnosis. Thank You.

Clinical indications for services requested:

1. _____ ICD.9 _____
2. _____ ICD.9 _____
3. _____ ICD.9 _____

PLEASE CHECK ALL THAT APPLY

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- o Consultation requested for _____ one time only
- o Consultation requested for _____ with Co-management
- o This is a high risk pregnancy and I request Co-management of pregnancy
- o Ultrasound with Consultation, if applicable
- o NT with 1st Trimester ultrasound (11 2/7 – 14 w)
  - o TRF# _____
- o Amniocentesis (> 15 weeks)
- o CVS (11 5/7 – 13 5/7 weeks)
- o Fetal Echocardiogram
- o Genetic Counseling
- o Patient Declines Genetic Counseling
- o Fetal Non-Stress Test (NST) please select
  - o One time only
  - o 2 times weekly until delivery
- o Multiple Gestation Management
- o Diabetes Management
- o Vaginal Ultrasound Cervical Length
  - o One time only
  - o Every 2 weeks until 22 weeks
- o Doppler Study – frequency as determined by perinatologist (please select)
  - o Umbilical Artery
  - o MCA – Middle Cerebral Artery
- o AMA, Abnormal AFP/FTS – Includes: Genetic Counseling/Ultrasound/CVS or Amniocentesis

APPOINTMENT: _____ TIME: _____ CPT CODES: _____