GARFIELD FAX (626) 571-1200 OR (909) 6231921

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

- 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: _________________________