WEST COVINA FAX (626) 337-4305 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 <u>all supporting documentation for your diagnosis</u>. 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: __________________________