

**Seattle Children’s TRI CITIES PRENATAL Appointment Request**

**Please fax to: (509) 392-4185 Scheduling phone: (509) 582-1711**

**8232 W. Grandridge Blvd. Kennewick, WA 99336**

**Referral Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Interpreter needed? □ No □ Yes Language \_\_\_\_\_\_\_\_**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Due Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alternate Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Referral reason/ Dx (REQUIRED):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Desired appointment timeframe: ­ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of Referring Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Practice name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Referring Provider Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| Appointment requested: (please check all that apply) All referrals to be reviewed by Clinical Team |
| **□ Ultrasound (check indication below)** **□ Routine Anatomy US** **□ Suspected fetal abnormality** **□ Abnormal genetic screening** **□ Multiple gestation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****□ Maternal Fetal Medicine Consultation****□ Fetal Echo + Pediatric Cardiology****□ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **□ Genetic Counseling (check indication below)** **□ Positive screening or diagnostic results** **□ Abnormal ultrasound findings** **□ Multiple miscarriages** **□ Pretest counseling for Amniocentesis** **□ Carrier (or possible carrier) of known genetic condition / family history of genetic condition** **□ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**PLEASE INCLUDE THE FOLLOWING WITH YOUR REFERRAL:**

* **Patient demographics + insurance information**
* **Previous Ultrasound reports**
* **OB clinic notes + lab results**
* **Labs and Genetic Screening results**