



Request for Services
 Celeste Sheppard, MD
 4100 Duval Road, Building II, Suite 201
 Austin, Texas 78759

512-339-1010 www.hcmfm.com fax 512-339-1011

Patient Information

Date: _____

Name: _____ DOB _____

Phone: home _____ work _____ cell _____

Insurance _____ ID# _____

Referring Provider _____ phone/cell/beeper _____ FAX _____

LMP: _____ EDC: _____ by scan on _____ @ _____
Please send records of previous ultrasound examinations. Date EGA or CRL

Ultrasound examinations/procedures with consultation as indicated:

<input type="checkbox"/> Complete targeted fetal survey (18-20 weeks)	<input type="checkbox"/> First trimester dating or visibility scan
Indication: <input type="checkbox"/> increased aneuploidy risk	<input type="checkbox"/> Basic 2nd / 3rd trimester exam (76805)
<input type="checkbox"/> increased NTD risk	<input type="checkbox"/> Growth, EFW, or repeat evaluation
<input type="checkbox"/> genetic scan	<input type="checkbox"/> Size greater or less than dates
<input type="checkbox"/> suspected abnormality:	<input type="checkbox"/> Breech/abnormal presentation
<input type="checkbox"/> other:	<input type="checkbox"/> Placental location or abnormality
	<input type="checkbox"/> Other:
<input type="checkbox"/> First trimester risk assessment (UltraScreen, 11-13 6/7 weeks)	<input type="checkbox"/> Preterm delivery risk / cervical length
<input type="checkbox"/> Fetal echocardiography. Indication:	<input type="checkbox"/> Amniocentesis <input type="checkbox"/> CVS
	<input type="checkbox"/> Multiple gestation: Twins/Triplets

Consultation and fetal assessment:

<input type="checkbox"/> Maternal medical condition:	<input type="checkbox"/> Diabetes, GDM with co-management
<input type="checkbox"/> Obstetric complications:	<input type="checkbox"/> DM, GDM without co-management

Fetal testing:

<input type="checkbox"/> Biophysical profile	<input type="checkbox"/> NST/AFI	<input type="checkbox"/> Amniocentesis for lung maturity
Indication:		(date: _____)

Consultation only:

Prepregnancy consultation for: _____ Other

Additional information/comments:

Appointment Date: _____ Time: _____ Authorization# _____

Please fax the prenatal record, maternal blood tpe and pertinent test results for all consultations in order for us to see your patient. Thank you!