**The Center for Perinatal Medicine/Northside Hospital**

**Georgia Perinatal Consultants Appointment Request FAX to: 404.845.5155**

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| --- | --- | --- | --- | --- | --- | --- |
| Northside  Women’s Center  1000 Johnson Ferry Rd Atlanta 30342  (P) 404.851.8988  (F) 404.851.6813 | Forsyth  Women’s Center  1800 Northside-Forsyth Dr  Cumming 30041  (P) 770.292.2942  (F) 770.292.2819 | Cherokee  684 Sixes Dr  Suite 230  Holly Springs 30115  (P) 770.926.1027  (F) 770.926.4075 | Alpharetta  11975 Morris Rd  Suite 130  Alpharetta 30005  (P) 770.667.4240  (F) 770.667.4242 | Kennestone  699 Church St  Suite 200  Marietta 30060  (P) 770.424.4488  (F) 770.424.0334 | Piedmont  77 Collier Rd  Suite 3130  Atlanta, 30309  (P)404.351.3574  (F)404.351.4739 | Fayette  1279 Hwy 54 W  Suite 210  Fayetteville, 30214  (P)770.376.6367  (F)770.376.6369 |

# Patient Name: Date of Birth:

**Address: City:**

**Zip:**

**Best # to Reach**:

**Alternate Phone**:

Primary Language is other than English – please specify:

**Primary Insurance**:

# Requested Procedure/Service: LMP: / /

**EDC:** / /

Early Ultrasound for dates, viability Genetic Counseling Consultation only

Anatomic Assessment 1st Trimester Screening (11.6 – 13.6 weeks)

Fetal Well Being / BPP CVS (11.6 – 13.6 weeks)

Cervix Check / Transvaginal Ultrasound Amniocentesis ( ≥ 15 weeks)

Amnio for Lung Maturity: Date of scheduled Delivery/C-Section: / /

NST Injection – please indicate:

# Reason for Exam/Consultation: ICD-10: (MUST INCLUDE)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prior History of: miscarriage(s) pre-term labor pre-term delivery Other:

Rule out anomalies Abnormal Ultrasound Finding Cervical Incompetence IUGR Confirm dates

Abnormal screen result – please specify: Multiples – How many:

AMA Diabetes Hypertension Other medical:

Family history and/or current medications:

**Location Preference**: None or

**MD Preference**: None or

# Specific Date for patient to be seen or time frame:

**Requested by**: Referring MD: Contact Person:

Office Phone: Office Fax:

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**CPM/GPC USE ONLY:**

**Appointment Details**: Appointment Date: / /

Time: Location:

GPC Physician:

Confirmation #:

Scheduled By: Confirmed appointment date and time with patient

\*\*\*Once appointment is confirmed, please fax all pertinent medical history including prenatal record, labs, etc. to the scheduled location.\*\*\*