GEORGIA PERINATAL CONSULTANTS

Patient Name _____ Age _____ Birthdate_____
(First Name) (Middle) (Last Name) (Preferred Name)

Address _____Home Phone (___) _____

City _____State _____Zip Code _____ Cell Phone (___) _____

Email Address _____Primary Language if other than English _____
please specify language

Insurance Carrier: Send Front and Back copies of the patient's insurance card(s) along with this form

Referring Physician / Midwife _____Office Phone: _____Fax: _____

Contact at office completing this form: _____Phone or Extension: _____

Location preference (please check the preferred location and fax this form along with; patient records, demographic sheet, insurance card(s), and insurance authorizations to the number at the location selected below and provide a copy of this form to the patient):

- ◯ NORTHSIDE Women's Center – Atrium Level, 1000 Johnson Ferry Road, NE, Atlanta, GA 30342, Tel: (404) 851-8988 |**Fax: (404) 845-5155**
- ◯ PIEDMONT - 77 Collier Road, NW, Suite 3130, Atlanta, GA 30309, Tel: (404) 351-3574 |**Fax: (404) 351-4739**
- ◯ MIDTOWN - 1110 West Peachtree Street, Suite 1000, Atlanta, GA 30309, Tel: (404) 898-2550 |**Fax: (404) 845-5155**
- ◯ KENNESTONE - Kennestone Outpatient Pavilion 699 Church Street NE, Suite 200, Marietta, GA 30060, Tel: (770) 424-4488 |**Fax: (770) 424-0334**
- ◯ ALPHARETTA - 11975 Morris Road, Suite 130, Alpharetta, GA 30005, Tel: (770) 667-4240| **Fax: (404) 845-5155**
- ◯ FORSYTH - 1800 Northside Forsyth Drive, Suite 240, Cumming, GA 30041, Tel: (770) 292-2942 | **Fax: (404) 845-5155**
- ◯ CHEROKEE - 460 Northside Cherokee Boulevard, Suite 320, Canton, GA 30115, Tel: (770) 721-9340 |**Fax: (404) 845-5155**
- ◯ FAYETTE - 1279 Hwy 54 West, Suite 210, Fayetteville, GA 30214, Tel: (770) 376-6367 |**Fax: (770) 376-6369**
- ◯ GWINNETT - 500 Medical Center Boulevard, Suite 130, Lawrenceville, GA 30046, Tel: (404) 325-1532 | Fax: **(404) 845-5155**
- ◯ **MD preference:** _____or □ **No preference**

Requested Procedure/Service: LMP: ____/____/____ EDC: _____/_____/_____

☐ 1st Trimester Screening (11.6 -13.6 weeks)
☐ Amniocentesis
☐ Anatomic Assessment
☐ Cervix Check/ Transvaginal Ultrasound
☐ Consultation only
☐ CVS (11.6-13.6 weeks)
☐ Early Ultrasound for dates, and viability
☐ Fetal Well Being/ BPP
☐ Genetic Counseling
☐ NST

Reason for Exam/Consultation (Check a box below) ICD-10: (*MUST BE INCLUDED*): _____

Prior History of: ☐ Miscarriage(s) ☐ Pre-term labor ☐ Pre-term delivery ☐ Other:

☐ Abnormal Ultrasound Findings ☐ Abnormal screen result - please specify: _____

☐ Cervical Incompetence ☐ IUGR ☐ Confirm dates ☐ Rule out anomalies ☐ Multiples- How many: _____

☐ AMA ☐ Diabetes ☐ Hypertension ☐ Other medical: _____

☐ Family history and/or current medications: _____

Appointment Details for GPC and CPM Use Only:

Appointment Date: _____ Time: _____ Location: _____

Insurance Authorization: _____

GPC Physician: _____ Scheduled by: _____ ☐ Confirmed date and time with patient

Fax this form once scheduled back to the referring physician

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