



**ORDERS • PERINATAL DIAGNOSTIC CENTER (PDC)  
 REFERRING PHYSICIAN ORDERS**

Medical Record Number

Patient Name

Addressograph or Label – Patient Name, Medical Record Number

Physician: Check all orders that pertain to the patient. Date, time & sign all orders.

Please have your patient call to schedule appointment

Perinatal Diagnostic Center: (650) 725-7030

Genetic Counseling: (650) 723-5198

**EDC:** \_\_\_\_\_ **LMP:** \_\_\_\_\_  Regular periods  Irregular periods

Plurality:  Singleton  Twins  Other: \_\_\_\_\_

History of Uterine Surgery:  C-Section  Myomectomy  Other: \_\_\_\_\_

**PROCEDURE REQUESTED**

**ICD-9 Code** \_\_\_\_\_

- OB Ultrasound (with consultation if applicable): Frequency: \_\_\_\_\_
- Amniocentesis/OB Ultrasound (will include Genetic Counseling)
- Genetic Counseling Only
- Chorionic Villus Sampling with 1<sup>st</sup> trimester ultrasound (wth Genetic Counseling)
- Nuchal Translucency with 1<sup>st</sup> trimester ultrasound (with Genetic Counseling)
- Nuchal Translucency with 1<sup>st</sup> trimester ultrasound (without Genetic Counseling)
- Biophysical Profile: Frequency: \_\_\_\_\_
- Non-Stress Test: Frequency: \_\_\_\_\_
- Amniotic Fluid Index: Frequency: \_\_\_\_\_
- NST/AFI: Frequency: \_\_\_\_\_
- Umbilical Artery Doppler/Ultrasound: Frequency: \_\_\_\_\_
- Middle Cerebral Artery Doppler/Ultrasound: Frequency: \_\_\_\_\_
- MFPR Consultation/Ultrasound/Procedure
- Fetal MRI/Consultation/Ultrasound (with Genetic Counseling if applicable)

**REASON FOR PROCEDURE**

- |   |   |
|---|---|
| <input type="checkbox"/> Screening for malformations                  | <input type="checkbox"/> Advanced maternal age                          |
| <input type="checkbox"/> Previous history of _____                    | <input type="checkbox"/> Family history of _____                        |
| <input type="checkbox"/> Abnormal Analytes _____                      | <input type="checkbox"/> Post dates                                     |
| <input type="checkbox"/> Teratogen exposure _____                     | <input type="checkbox"/> Decreased fetal movement                       |
| <input type="checkbox"/> Uterine abnormality _____                    | <input type="checkbox"/> Cervical Insufficiency                         |
| <input type="checkbox"/> Antiphospholipid syndrome/thrombophilias     | <input type="checkbox"/> Diabetes                                       |
| <input type="checkbox"/> Size larger than dates                       | <input type="checkbox"/> Premature labor abnormality:<br>Describe _____ |
| <input type="checkbox"/> Size smaller than dates                      | <input type="checkbox"/> Suspected fetal anomaly:<br>Describe _____     |
| <input type="checkbox"/> Polyhydramnios                               | <input type="checkbox"/> Other: _____                                   |
| <input type="checkbox"/> Oligohydramnios                              | _____   |
| <input type="checkbox"/> Isoimmunization – Rh or other _____          | _____   |
| <input type="checkbox"/> Hypertension/Pre-eclampsia                   | _____   |
| <input type="checkbox"/> Placental Abnormality (previa, accreta, etc) | _____   |

(Genetic Counseling provided if indicated)

\*Blood type \_\_\_\_\_ \*Antibody screen \_\_\_\_\_ MCV \_\_\_\_\_ \*Date drawn \_\_\_\_\_

\* Required for Amnio, Chorionic Villus Sampling, MFPR procedures

**For all procedures fax to: Perinatal Diagnostic Center (PDC) 725-9877**

DATE	TIME	Provider Signature:	Pager:	Noted by:	Date/Time
		<b>PRINT</b> Provider Name:		RN Signature	Date/Time
Orders signed					