

# FETAL CARE CENTER INTAKE/REFERRAL FORM

In affiliation with CHI Health | 8200 Dodge Street, Omaha, NE 68114



Thank you for allowing us to participate in the care of your patient. The Fetal Care Center provides a unique service to parents and families through pre-delivery education and personalized, comprehensive care coordination between the obstetrician, the maternal-fetal medicine specialists and the pediatric subspecialists. Through a multidisciplinary approach, our specialists will determine and implement a coordinated plan to provide the best care possible to expectant mothers and their unborn children.

The Fetal Care Center coordinator, Samantha Wullschleger, BSN, RN, will contact your patient upon receipt of this referral form. Comprehensive evaluations and testing will be scheduled and coordinated through the Fetal Care Center.

## PATIENT INTAKE INFORMATION

DATE OF REFERRAL: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CELL PHONE NUMBER: \_\_\_\_\_

WORK PHONE NUMBER: \_\_\_\_\_

EMAIL: \_\_\_\_\_

(EDC): \_\_\_\_\_

MATERNAL DIAGNOSIS: \_\_\_\_\_

FETAL DIAGNOSIS: \_\_\_\_\_

GESTATIONAL AGE: \_\_\_\_\_

TRANSLATOR NEEDED?  NO  YES - LANGUAGE: \_\_\_\_\_

## REFERRAL INFORMATION

REFERRING M.D. NAME: \_\_\_\_\_

FACILITY: \_\_\_\_\_

PHONE: \_\_\_\_\_

FAX: \_\_\_\_\_

PRACTICE CONTACT/REFERRAL COORDINATOR: \_\_\_\_\_

## REASON FOR REFERRAL

### Children's pediatric specialty consultation requested:

- |                                                       |                                                       |
|-------------------------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> Cardiology                   | <input type="checkbox"/> Nephrology                   |
| <input type="checkbox"/> Cardiothoracic Surgery       | <input type="checkbox"/> Neurosurgery                 |
| <input type="checkbox"/> Craniofacial/Plastic Surgery | <input type="checkbox"/> Orthopedics                  |
| <input type="checkbox"/> ENT                          | <input type="checkbox"/> Palliative Care/Hand-in-Hand |
| <input type="checkbox"/> Genetic Counseling           | <input type="checkbox"/> Pediatric Surgery            |
| <input type="checkbox"/> Neonatology                  | <input type="checkbox"/> Urology                      |
| <input type="checkbox"/> Other: _____                 |                                                       |

### Imaging:

- |                                       |                                    |
|---------------------------------------|------------------------------------|
| <input type="checkbox"/> Fetal Echo   | <input type="checkbox"/> Fetal MRI |
| <input type="checkbox"/> Other: _____ |                                    |

Please complete this form and fax it, along with all patient medical records (including prenatal record, labs, ultrasounds and demographic and insurance information), to: 402-955-4374, or email Samantha Wullschleger, [swullschleger@ChildrensOmaha.org](mailto:swullschleger@ChildrensOmaha.org), or call 402-955-3030.

## THE FETAL CARE CENTER

For information or referral 24/7, call the Physicians' Priority Line: 855-850-KIDS (5437)