

# Prematurity Prevention Program FAX REFERRAL FORM

## Prematurity Prevention Program/Multiple Gestation Clinic

University of Washington Medical Center  
Maternal and Infant Care Clinic (MICC)  
Box 356159  
Seattle, WA 98195-6159

Voice Mail: (206) 598-6959  
Prem. RN Pager: (206) 598-4070  
Fax: (206) 598-4694

Today's Date \_\_\_\_\_

### PATIENT INFORMATION

Patient Name \_\_\_\_\_ G \_\_\_ P \_\_\_ LMP \_\_\_\_\_ EDC \_\_\_\_\_

GA Today \_\_\_\_\_ (GA based on U/S at \_\_\_\_\_ weeks) Date of last U/S \_\_\_\_\_

DOB \_\_\_\_\_ Medications \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance \_\_\_\_\_ Group Health # (if applicable) \_\_\_\_\_

Reason(s) for Referral:  Previous preterm labor  Hx PPRM  Multiple gestation  
 Previous preterm birth  Hx 2nd trimester loss(es)  Uterine anomalies  
 Current preterm labor  Hx cervical surgery  Cervical incompetence  
 Hx cerclage  Shortened cervix on U/S

Type of Referral:  Consult Only  Co-management  Transfer of Care

### REFERRING PROVIDER INFORMATION

Name \_\_\_\_\_ UPIN # \_\_\_\_\_ Contact Person \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Backline Phone \_\_\_\_\_ FAX \_\_\_\_\_

Delivery Hospital \_\_\_\_\_

### PATIENT REFERRAL CHECKLIST

Please be sure to fax the following, along with this completed form, to (206) 598-4694:

- All prenatal labs, including blood type and RH factor
- Prenatal flow sheets and chart notes with fetal measurements
- All fetal U/S reports with individual measurements (fetal biometry)
- If interpreter needed, language \_\_\_\_\_
- Insurance information

#### Office Use Only:

Reg. \_\_\_\_\_ NST \_\_\_\_\_ U/S \_\_\_\_\_  
MD \_\_\_\_\_ Pt. Contact \_\_\_\_\_ Initials \_\_\_\_\_