# Prenatal Testing Center (MFM)

85 Jefferson St. Suite 625 Hartford, CT 06106
Tel: 860-972-2884 Fax 860-221-3660

## PATIENT INFORMATION

| LAST NAME / MAIDEN NAME (REQUIRED) | FIRST NAME | M.I. | ETHNICITY: / RACE: |
|---|---|---|---|
| DATE OF BIRTH | SS# (last 4 digits required) | | INSURANCE (PLEASE ATTACH COPY) |
| ADDRESS | CITY | ZIP | APT/FL |

PHONE
HOME CELL WORK

## EMERGENCY CONTACT

NAME: TELEPHONE#: RELATIONSHIP:

## PREGNANCY INFORMATION

| EDC | LMP | BLOOD TYPE | TWINS Y ☐ N ☐ |
|---|---|---|---|

## PLEASE SELECT APPOINTMENT TYPE

☐ First Trimester Screening
with Consult & Diagnostic Testing if needed
☐ CELL FREE DNA TESTING

☐ Obstetrical Ultrasound or detailed Ultrasound
with Consult & Diagnostic Testing if needed
(LEVEL II)

☐ Chorionic Villus Sampling/ Genetic Amniocentesis

☐ Antepartum Fetal Testing ( NST/ BPP/ AFI as indicated )

☐ FETAL ECHO

☐ Genetic Consult: Please fax all records

☐ MFM Consult: Please fax all records

## REASON FOR REFERAL

COMMENTS/INDICATION:

| REFERING MD: | OFFICE CONTACT PERSON: OBGYN Group of Eastern Connecticut | |
|---|---|---|
| OFFICE PHONE #: 860-646-1157 | EXT: — | FAX#: 860-646-9877 |

## PREFERRED LOCATION

| ☐ HARTFORD | ☐ WEST HARTFORD | ☐ GLASTONBURY |
|---|---|---|
| 85 JEFFERSON ST | 65 MEMORIAL RD | 330 WESTERN BLVD |
| SUITE # 625 | SUITE # 410 | SUITE # 103 |

## APPOINTMENT INFORMATION

| | |
|---|---|
| **DATE:** | PLEASE FAX ALL DOCUMENTS WITH BOOKING SHEET |
| **TIME:** | ☐ QUAD SCREEN/ MSAFP / PRENATAL LABS |
| **LOCATION:** | ☐ ACOG/ FLOW SHEETS |
| **COMMENTS:** | ☐ CHECK BOX IF DECLINED GENETIC TESTING |

This form will be faxed to the fax number indicated with your patients appointment information. Please notify your patient of their appointment. Please allow 48 hrs for a response.

AUG 2 2 2016