

WakeMed Raleigh
 Raleigh Medical Park
 23 Sunnybrook Road
 Suite 316
 Raleigh, NC 27610

WakeMed North
 10880 Durant Road
 Suite 300
 Raleigh, NC 27614

Holly Springs
 101 Cotten Lane
 Holly Springs, NC 27540

Cary
 210 Ashville Avenue
 Suite 305
 Cary, NC 27518

PROVIDERS: *(Please check if referring to a specific provider.)*

- Carmen Beamon, MD, MPH, FACOG
- James Edwards, MD, FACOG
- Bassam Rimawi, MD
- Emily Willner, MD

Genetic Counselors:

- Missy Gilbert, MS
- Courtney Yerxa, MS, CGC
- Cheryl Dickerson, MS, CGC
- Maria Keever, MMSc, CGC

Appointments: 919-350-6002

Fax: 919-350-6003

Pregnancy Diabetes Management

- Heather Smith, PA
- Sharon Lambert, RN, CDE

REQUEST FOR SERVICES

Date of Request: _____ Same Day Request? No Yes (if yes, please call MFM office)

Preferences for appointment (Date/Time): _____

Location: Raleigh North Holly Springs Cary *(Please circle your preferred location. Circle all if no preference)*

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____ DOB: _____

Preferred Contact Phone #: _____ Medical Insurance Company: _____

Insurance ID: _____ Group ID: _____ *(Please fax insurance card with referral)*

G/P: _____ LMP: _____ EDD: _____ Is EDD by LMP or Ultrasound? *(Circle one)*

If prior ultrasound performed: Date of ultrasound: _____ Gestational age at time of prior ultrasound: _____

Blood type: _____ Antibody screen: _____ BMI: _____

Prior aneuploidy screening: No Yes* *(If yes, please send copy of results with referral.)*

REFERRING PROVIDER INFORMATION

Practice Name: _____

Provider Name: _____ Practice Address: _____

Phone Number: _____ Fax Number: _____

Requested Services (Mark ALL that apply)

Ultrasound	Consultation
<input type="checkbox"/> First Trimester/Viability/Dating/Chorionicity (consult if needed) <input type="checkbox"/> First Trimester Aneuploidy Screening/Nuchal Translucency (consult if needed) <input type="checkbox"/> Basic anatomy (consult if needed) <input type="checkbox"/> Comprehensive anatomy (consult if needed) <input type="checkbox"/> Fetal Echocardiogram (consult if needed). <input type="checkbox"/> Follow-up ultrasound (only if prior MFM ultrasound) (consult if needed) <input type="checkbox"/> Saline Infused Sonohysterogram / 3D Gyn Ultrasound <input type="checkbox"/> Cervical Length (consult if needed) <input type="checkbox"/> Biophysical Profile (consult if needed) <input type="checkbox"/> Other (specify): _____	<input type="checkbox"/> MFM Physician Counseling <input type="checkbox"/> Diabetes Education <input type="checkbox"/> Genetic Counseling <input type="checkbox"/> Diabetes Management Indication for consultation/Additional comments: _____ _____ _____

Indications/Diagnosis (Mark ALL that apply)

<input type="checkbox"/> Screening for aneuploidy/structural abnormality <input type="checkbox"/> Uncertain Gestational age <input type="checkbox"/> Abnormal Ultrasound - Specify: _____ <input type="checkbox"/> Large for Dates Small for Dates <input type="checkbox"/> Diabetes - Preexisting or Gestational <input type="checkbox"/> Hypertension - Preexisting or Pregnancy-induced <input type="checkbox"/> Multiple gestation: # _____	<input type="checkbox"/> Advanced maternal age <input type="checkbox"/> Abnormal aneuploidy screening <input type="checkbox"/> Alloimmunization - Specify Antibody: _____ <input type="checkbox"/> Positive Family History - Specify: _____ <input type="checkbox"/> Medication Exposure - Specify: _____ <input type="checkbox"/> Patient request <input type="checkbox"/> Preconception counseling	Other indication: (Please specify) _____ _____ _____
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*****Please fax records >= 2 days before scheduled appointments*****

*Using the phone and fax numbers from the top of this form, please call for an appointment or fax this request to our office (along with appropriate records, notes, lab results, insurance info where applicable). **Thank you for your referral.***

To download this form electronically, visit wakemedphysicians.com and click on "Referring Providers."