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

North Raleigh
10880 Durant Road, Suite 300
Raleigh, NC 27614

Cary
210 Ashville Avenue, Suite 305
Cary, NC 27518

WakeMed Physician Practices

Maternal Fetal Medicine

Appointments: 919-350-6002
Fax: 919-350-6003

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

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

Genetic Counselors:
- ☐ Cheryl Dickerson, MS,CGC
- ☐ Missy Gilbert, MS, CGC
- ☐ Maria Keever, MMSc, CGC
- ☐ Courtney Yerxa, MS, CGC

Pregnancy Diabetes Management
- ☐ Heather Smith, PA-C, CDCES
- ☐ Nicole Federica, MS, RDN, LD

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

Indications/Diagnosis (Mark ALL that apply)

☐ Screening for aneuploidy/structural abnormality	☐ Advanced maternal age	Other indication: (Please specify)
☐ Uncertain Gestational age	☐ Abnormal aneuploidy screening	_____
☐ Abnormal Ultrasound - Specify: _____	☐ Alloimmunization - Specify Antibody: _____	_____
☐ Large for Dates Small for Dates	☐ Positive Family History - Specify: _____	_____
☐ Diabetes - Preexisting or Gestational	☐ Medication Exposure - Specify: _____	_____
☐ Hypertension - Preexisting or Pregnancy-induced	☐ Patient request	_____
☐ Multiple gestation: # _____	☐ Preconception counseling	

*****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."