Office: (816) 541-2700 Fax: (877) 670-9432

HIGH RISK Pregnancy CENTER OF KANSAS CITY

Provider Service Request

Patient Name:_____ DOB: _____

Patient Primary Contact #: _____Secondary Contact #: _____

Please attach demographic sheet and copy of insurance Information/Card (required prior to scheduling the patient)

Requesting Provider/Practice: _____

Office Contact Person: _____ Office #: _____

# of FETUS: _____ **EDC:** _____ **by** ☐**LMP** ☐**US** ☐**IVF**

INDICATION (s): _____

Ultrasound(s): with additional diagnostic testing and consultation when clinically indicated

- ☐ First Trimester Ultrasound (< 14 weeks)
- ☐ Nuchal Translucency Scan (11 - 13 $^{6}/_{7}$ wks.)
- ☐ Amniocentesis
- ☐ Transvaginal Ultrasound for Cervical Length (≥16 weeks)
- ☐ Complete Ultrasound (growth or anatomy)
- ☐ Detailed (Level 2) Ultrasound (≥18 weeks)
- ☐ Fetal Echocardiogram by MFM (≥ 23 weeks)
- ☐ Biophysical Profile w/o NST
- ☐ Ultrasound evaluation for external version

MFM Consultation: with additional diagnostic testing as determined by MFM

- ☐ consult with recommendations
- ☐ consult with co-management during pregnancy
- ☐ preconception consultation

Please Provide the following information:

- Current Prenatal Records
- Prior Ultrasounds
- ALL Prenatal Labs

Provider Signature: _____ **Date:** _____