Ocean Perinatal Medical Group INC
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Patient Information:

Patient Name _____ **EDC** _____ **G** ____ **P** ____

DOB _____ **Age** _____ **Ht** _____ **Wt** _____ **(lbs)** **Primary Language** _____

Address _____ **Phone** _____

Insurance Plan _____ **Number/ID** _____

Referring office please:

- ☐ *Fax/email copy of insurance card*
- ☐ *Fax/email copy of H&P, relevant records*
- ☐ *Obtain authorization for all HMO plans*

Medical & Obstetrical History	*Ultrasound Services Requested*
Relevant history/referral details: _____ _____ _____ _____ _____ _____ _____ _____ **Indications:** ☐ Routine US screening ☐ Suspected anomaly ☐ Other _____	**Early/other:** ☐ Dates/viability (76801, 76805) ☐ Consultation only (99241-99245) **Singleton Pregnancy** ☐ NT screening ***[11-13 weeks]*** (76813, 76801) ☐ Anatomical survey ***[18-22 weeks]*** (76811) ☐ Growth US (76805, 76816) **Twins** ☐ Twins NT (76813, 76814) ☐ Twins anatomy (76811, 76812, 76817) ☐ Twins growth (76810, 76805, 76810) **Requested Time Frame:** ☐ Emergent (1-3 days) ☐ Urgent (within 1 week) ☐ Routine (usual screening intervals)

Provider Information:

Provider Name _____ **Phone** _____ **Fax** _____

Provider Signature _____

Office Use: *Patient scheduled on* _____ *Appointment confirmed (initials)* _____