University of Kentucky Women's Health
Maternal Fetal Medicine

125 E. Maxwell Street
Lexington, Ky. 40508
Phone: 859-218-4404
Fax: 859-218-7595

REQUEST OF SERVICE FORM **Date:** _____

Patient Information

Name: _____ DOB: _____

SSN: _____ Phone: _____

Address: _____

City/State/Zip: _____

EDD: _____ Today's gestational age: _____

Referring Physician Information

Provider: _____

Address: _____ City/State/Zip: _____

Office #: _____ Fax #: _____

Type of appointment needed

- ☐ MFM ultrasound with consult as needed
- ☐ MFM ultrasound and co-management of care throughout pregnancy
- ☐ Transfer of care to UK MFM for remainder of pregnancy
- ☐ MFM consult (preconception only)
- ☐ Genetics consult

Please indicate the reason for your referral (select all that apply)

- ☐ Maternal indication (diabetes, advanced maternal age, chronic/gestational hypertension, increased BMI, etc.): _____
- ☐ Prior pregnancy complications (pre-term birth, premature cervical shortening, IUFD, etc.): _____
- ☐ Abnormal fetal growth: _____
- ☐ Fetal anomaly/abnormal ultrasound finding: _____
- ☐ Genetic counseling (pre-conception, family history, abnormal screening/NIPT, etc.): _____
- ☐ Other: _____

In order to process your referral in a timely manner, please complete this request of service form and fax the following documents to our office: front/back copy of insurance card, face sheet with demographic information, prenatal records including lab work results, office visit notes, and previous ultrasound reports.