CEDARS-SINAI®

FETAL ECHOCARDIOGRAM REFERRAL

Date: ____ Form Completed By: ____

Contact Name: ____ Contact Phone: ____

Patient Name: ____ SSN: ____

Address: ____ DOB: ____

City, ST, Zip: ____ Phone: ____

Referring OB: ____ OB Phone: ____

Referring MFM: ____ MFM Phone: ____

OB Address: ____ OB Fax: ____

OB City, ST, Zip: ____

Reason for Referral: ____

Urgency: ☐ ASAP (less than one week) ☐ Next Available (less than three weeks)
☐ 4-6 Weeks ☐ 6-8 Weeks ☐ Other

LMP: ____ EDD: ____ Last US: ____ GA @ US: ____

Current GA: ____ G/P: ____

Interpreter Required: ☐ Yes ☐ No Preferred Language: ____

Insurance: ____

Managed Care: ☐ Yes ☐ No ☐ HMO ☐ PPO

Subscriber Name: ____ Subscriber DOB (if other than patient): ____

Policy #: ____ Group #: ____

Customer Svc Phone #: ____

Authorization Required: ☐ Yes ☐ No Auth # (if already acquired): ____

Preferred appointment location:

☐ Heart Institute
127 S. San Vicente Blvd
Suite A3600
Los Angeles, CA 90048

☐ Prenatal Diagnosis Center:
444 S San Vicente Blvd
Suite 1001
Los Angeles, CA 90048

☐ No preference

Will any other testing, appointments, consultations, need to be coordinated with this visit? ☐ No ☐ Yes

Please fax or securely email this referral form AND the most recent prenatal visit notes to: **310-423-6795** or **congenitalheart@cshs.org**

24-hour access to Pediatric/Congenital Cardiology: **310-423-1153**

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