

**Florida Perinatal Center LLC**  
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**APPOINTMENT REQUEST FORM**

*Please fax form and all other scheduling correspondence/records to (954) 255-1989.*

Date: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Contact Person: \_\_\_\_\_

Office Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Backline: \_\_\_\_\_

Patient Name (Please Print): \_\_\_\_\_

Social Security # : \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Mobile: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Insurance Company : \_\_\_\_\_ PO Box: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_ Phone # : \_\_\_\_\_

Insured Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  HMO  PPO  POS  OTHER

LMP: \_\_\_\_\_ EDC: \_\_\_\_\_ G \_\_\_ P \_\_\_ A \_\_\_ L \_\_\_ LOCATION: CORAL SPRINGS \_\_\_\_ BOCA RATON \_\_\_\_

**Preferred day of the week/time for the appointment** \_\_\_\_\_

<p><b>INDICATION/DIAGNOSIS:</b></p> <p><input type="checkbox"/> Abnormal genetic screen</p> <p><input type="checkbox"/> AMA</p> <p><input type="checkbox"/> Decreased fetal movement</p> <p><input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> Gestational</p> <p><input type="checkbox"/> Pre-gestational</p> <p><input type="checkbox"/> Fetal abnormality: _____</p> <p><input type="checkbox"/> Habitual Abortion</p> <p><input type="checkbox"/> Hypertension</p> <p><input type="checkbox"/> HX of fetal demise</p> <p><input type="checkbox"/> Incompetent cervix</p> <p><input type="checkbox"/> IVF</p> <p><input type="checkbox"/> Hypothyroid</p> <p><input type="checkbox"/> Hyperthyroid</p> <p><input type="checkbox"/> HX of genetic disorders:</p> <p>_____</p> <p>_____</p>	<p><input type="checkbox"/> Size unequal to dates</p> <p><input type="checkbox"/> Medication or drug exposure</p> <p><input type="checkbox"/> Multiples Gestation</p> <p><input type="checkbox"/> Obesity</p> <p><input type="checkbox"/> Oligohydramnios</p> <p><input type="checkbox"/> Placenta Previa</p> <p><input type="checkbox"/> Polyhydramnios</p> <p><input type="checkbox"/> Pre-eclampsia</p> <p><input type="checkbox"/> Other: _____</p> <p><b>SERVICES REQUIRED:</b></p> <p><input type="checkbox"/> Consultation Only</p> <p><input type="checkbox"/> Consultation with sono as indicated</p> <p><input type="checkbox"/> Diabetic Consult</p> <p><input type="checkbox"/> Genetic Consult</p>	<p><b>FETAL EVALUATION:</b></p> <p><input type="checkbox"/> Integ/Seq screen only</p> <p><input type="checkbox"/> Integ/Seq screen with 1st trimester sono</p> <p><input type="checkbox"/> 1st trimester sono</p> <p><input type="checkbox"/> NT Only</p> <p><input type="checkbox"/> Anatomy/Level II</p> <p><input type="checkbox"/> 34 Week / Growth Scan</p> <p><input type="checkbox"/> CVS</p> <p><input type="checkbox"/> Amniocentesis</p> <p><input type="checkbox"/> Transvaginal</p> <p><input type="checkbox"/> BPP/NST</p> <p><input type="checkbox"/> BPP Only</p> <p><input type="checkbox"/> Fetal Echo</p> <p><input type="checkbox"/> NIPT (Non-invasive pre- natal test)</p> <p><input type="checkbox"/> Other:</p> <p>_____</p>
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