Service request order / Referral request order
Minnesota Perinatal Physicians
A service of Abbott Northwestern, United and Mercy Hospitals

To schedule a patient: **Place an order in Excellian using "Consult to Perinatology" and route order to MPP scheduling pool (1000000) or fax this form to 612-863-5697.**

Please provide all pertinent medical records. Lack of records may delay the patient visit.

Patients will be scheduled for appointments based on the diagnosis and service requested.
Location for visit will be determined based on medical need and patient preference.

***We invite you as the referring physician, midwife or APRN to speak with one of our MPP physicians directly at 612-863-4502 if you feel that your patient has special needs or requires urgent attention.**

Patient name______________________________________ Best contact number____________________________

Please circle Singleton Twins Triplets Quads DOB_____________ EDC____________________

Diagnosis____

What would you like us to discuss/review with your patient? ____

☐ **I approve MPP to schedule the patient for appropriate visit type (check no other boxes) or select from the following visit types:**

- ☐ Pre pregnancy consult
- ☐ Consult on pregnancy risks/management
- ☐ Antenatal testing/delivery recommendations
- ☐ Medication review
- ☐ Level II, suspected anomaly, poor visualization or IUGR
- ☐ Genetic counseling only

MFM procedure only visits:

- ☐ Level II, Routine only (20-23 weeks)
- ☐ Follow up growth (only if L2 with MPP)
- ☐ Twice weekly BPP/NST testing
- ☐ Weekly Dopplers
- ☐ Weekly BPP/NST
- ☐ CVS/Amnio (includes GC if needed)
- ☐ First trimester screen

Choose one box:

☐ **I approve future ultrasound and testing recommendations be scheduled with MPP and ordered under my name**
☐ **Please make recommendations only, I will order additional testing/ultrasound if desired**

Clinic contact person ___________________________Clinic number____________________________________

Name of physician/providers to receive report and updates____

Allina providers will receive an in basket report. ☐ Non Allina providers will receive a fax report.

Fax#______________________________________

Ordering Provider (please print) ____

Provider signature____ Date________________________

6.1.2018