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Office Use Only
MRN # _____

Office Phone: 719-622-3442
Office Fax: 888-310-9460

- Colorado Springs-6071 E. Woodmen Rd, Ste 440
- Alamosa-SLV Regional Medical Center- 106 Blanca Ave
- Pueblo-St Mary Corwin - 1008 Minnequa Ave, Ste 5220

Please fax referral form, insurance card(s), all labs including blood type, all ultrasound reports, any carrier screen results, and first/second trimester screening.

_____ Patient Name	_____ DOB	_____ Age	_____ Phone
_____ Referring Physician/CNM/NP/PA	_____ Office Phone	_____ Office Fax	

Preconception counseling : _____

G: _____ P: _____ LMP: _____ EDD: _____ By U/S By LMP

BMI: _____ (If BMI greater than 40, patient will need to be seen in Colorado Springs)

Please Select one: __ Singleton __ Twin __ Triplet __ Other: _____

Diagnosis (Perinatal consult will be provided for these indications)		
<input type="checkbox"/> AMA	<input type="checkbox"/> Size Date Discrepancy	<input type="checkbox"/> Other medical Dx _____
<input type="checkbox"/> Obesity	<input type="checkbox"/> HTN	<input type="checkbox"/> Fetal anomaly _____
<input type="checkbox"/> Multiple gestation	<input type="checkbox"/> Family hx of _____	
<input type="checkbox"/> Abnormal outside Ultrasound _____		

Please Note: Gestational age appropriate anatomy survey will be assessed on all referrals

Comprehensive fetal evaluation consultation and follow-up as deemed necessary by perinatologist

Diabetes Co-Management DM Type: _____	
<input type="checkbox"/> Glucose Management	<input type="checkbox"/> Fetal Echo <input type="checkbox"/> Follow-up/Growth Ultrasound <input type="checkbox"/> BPP

Ultrasound Only
<input type="checkbox"/> First Tri NT(11-13.6 wks)
<input type="checkbox"/> Anatomy
<input type="checkbox"/> Growth
<input type="checkbox"/> Other _____

Ultrasound with Consult	Antepartum Monitoring/Testing
<input type="checkbox"/> MFM to Schedule Follow-up U/S	<input type="checkbox"/> Biophysical Profile
<input type="checkbox"/> First Trimester U/S	<input type="checkbox"/> MCA Doppler
<input type="checkbox"/> First Tri Screening NT (11-13.6 wks)	<input type="checkbox"/> UA Doppler
<input type="checkbox"/> Perinatology U/S (14-17.6 wks)	<input type="checkbox"/> Cervical Length
<input type="checkbox"/> Detailed Anatomy Scan	<input type="checkbox"/> Amniotic Fluid Assessment
<input type="checkbox"/> Fetal Echocardiogram	<input type="checkbox"/> CVS (10-13.6 Wks)
<input type="checkbox"/> Follow Up U/S / Growth	<input type="checkbox"/> Amniocentesis (15+ wks)

What time frame would you like patient seen? _____

If your patient needs to be seen right away, please call the office to speak with one of the physicians

Notes:
