Rocky Mountain Perinatology
1107 South Lemay Avenue, Suite 410, Fort Collins, CO 80524
970-294-4464, Fax 970-482-1973

Referral Form

1. Patient's Name: _____ Patient phone #: _____
DOB: _____ Primary language: _____
Appointment date: _____ Appointment time: _____
Referring Physician: _____ NPI #: _____
Referring Physician Phone #: _____ Fax #: _____

**** IF A REFERRAL OR PREAUTHORIZATION IS NECESSARY, PLEASE OBTAIN PRIOR TO SCHEDULING****

LMP: _____ EDC: _____ Blood Type: _____ G: _____ P: _____

Height: _____ Weight _____ BMI _____

Genetic Screening ☐ **Y** ☐ **N** Type & Results: _____

☐ Previous Ultrasound ☐ **Y** ☐ **N** EDC based U/S _____

2. Services Requested:
(Check all that apply)

- ☐ Preconception counseling
- ☐ Consultation
- ☐ Consultation w/Ultrasound, if applicable
- ☐ Detailed Comprehensive US w/consult (please indicate medical necessity)
- ☐ Ultrasound Only - Screening Ultrasound
- ☐ Biophysical Profile
- ☐ Amniocentesis
- ☐ 1st trimester screen for Down Syndrome
- ☐ MaterniT21 Plus
- ☐ Fetal Echocardiography
- ☐ Other service, please specify:

_____

Indication:

- ☐ Healthy Pregnancy – Screening Only
- ☐ Abnormal Genetic Screen (specify) _____
- ☐ Advanced Maternal Age
- ☐ Bleeding
- ☐ Choroid Plexus Cyst
- ☐ Diabetes Mellitus (specify if Gestational) _____
- ☐ History of Birth Defects/Genetic Disease (specify)

  _____
- ☐ Pregnancy resulting from In Vitro Fertilization
- ☐ Medication Exposure (list below)
- ☐ Multiple Gestation (specify) _____
- ☐ Oligohydramnios / ☐ Polyhydramnios
- ☐ Poor OB History
- ☐ Pre-eclampsia
- ☐ Size / Date Discrepancy (IUGR/LGA, specify) _____
- ☐ Suspected / Known Fetal Abnormality (specify)

  _____
- ☐ Other Signs or Symptoms (specify):

  _____

  _____

PHYSICIAN SIGNATURE: (required) _____

3. PLEASE FAX PRENATALS, PRENATAL LABS, ULTRASOUND REPORTS, GENETIC SCREENING RESULTS, COPY OF CURRENT INSURANCE CARD, AND ANY OTHER PERTINENT INFORMATION

Date_____

Name_____

Last **First** **Middle**

SSN _____ **DOB** _____ **AGE** _____

How well do you speak English? **Very Well** _____ **Well** _____ **Not Well** _____ **Not At All** _____

Language _____ **Religion** _____

Are you currently pregnant? ☐ **Yes** ☐ **No** **Due Date** _____

Last Menstrual Period ☐ **Definite** _____ **Referring Doctor** _____

☐ **Unknown**

Are there any problems with your current pregnancy? ☐ **Yes** ☐ **No** **If "Yes" please explain**

_____

_____

_____

Obstetric History

Please list past pregnancies starting with the first one:

Date	Weeks	Length of Labor	Birth Weight	Sex	Type of Delivery	Type of Anesthesia	Hospital/Doctor
Example: *2/2/2000*	*37 wks*	*6 hours*	*6lb 3oz*	*male*	*vacuum*	*Epidural*	*Las Vegas/Smith*

Total Pregnancies	Full Term	Premature	Abortions Induced	Miscarriages	Ectopics	Multiple Births	Living Children

Comments/Complications with previous pregnancies:_____

_____

_____

_____

Reviewed By:_____

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Review of Systems/Medical History

Please list medications you have taken in the last year or are currently taking:

Medication Taken	Dose	Date Taken

Please list any known allergies:

Have you used any street drugs since becoming pregnant? ☐ Yes ☐ No

If "Yes" what type _____

Have you consumed any alcohol since becoming pregnant? ☐ Yes ☐ No

If "Yes" what type _____

Do you smoke? ☐ Yes ☐ No

Do you have or have you had any of the following conditions?

Unexplained fever	☐ Yes	☐ No	☐ Unsure
Vision Problems	☐ Yes	☐ No	☐ Unsure
Hearing Loss	☐ Yes	☐ No	☐ Unsure
Ear Infections (other than childhood)	☐ Yes	☐ No	☐ Unsure
Sinus Problems	☐ Yes	☐ No	☐ Unsure
Repeated Nosebleeds	☐ Yes	☐ No	☐ Unsure
Long Term Sore Throat	☐ Yes	☐ No	☐ Unsure
Pneumonia	☐ Yes	☐ No	☐ Unsure
Asthma	☐ Yes	☐ No	☐ Unsure
Close contact with person with TB	☐ Yes	☐ No	☐ Unsure
Tuberculosis Vaccine (BCG)	☐ Yes	☐ No	☐ Unsure
Positive TB Skin Test	☐ Yes	☐ No	☐ Unsure
Unexplained Cough	☐ Yes	☐ No	☐ Unsure
Unexplained Shortness of Breath	☐ Yes	☐ No	☐ Unsure
Other Lung Problems	☐ Yes	☐ No	☐ Unsure
Heart Murmur	☐ Yes	☐ No	☐ Unsure

Mitral Valve Prolapse	☐ Yes	☐ No	☐ Unsure
Other Heart Valve Problems	☐ Yes	☐ No	☐ Unsure
Heart Attack	☐ Yes	☐ No	☐ Unsure
Heart Disease	☐ Yes	☐ No	☐ Unsure
Unexplained Chest Pains	☐ Yes	☐ No	☐ Unsure
Unexplained Fainting	☐ Yes	☐ No	☐ Unsure
Irregular Heartbeat	☐ Yes	☐ No	☐ Unsure
Other Heart Problems	☐ Yes	☐ No	☐ Unsure
High Blood Pressure in Pregnancy	☐ Yes	☐ No	☐ Unsure
High Blood Pressure, Other	☐ Yes	☐ No	☐ Unsure
Raynaud's Disease, Raynaud's Phenomenon	☐ Yes	☐ No	☐ Unsure
Poor Blood Circulation	☐ Yes	☐ No	☐ Unsure
Severe Nausea and Vomitting in Pregnancy	☐ Yes	☐ No	☐ Unsure
Severe Nausea and Vomitting before Pregnancy	☐ Yes	☐ No	☐ Unsure
Intestinal Problems (Irritable Colon, Crohn's Disease, etc.)	☐ Yes	☐ No	☐ Unsure
Dietary Restrictions	☐ Yes	☐ No	☐ Unsure
Unexplained Recurring Diarrhea	☐ Yes	☐ No	☐ Unsure
Constipation Problem	☐ Yes	☐ No	☐ Unsure
Heartburn, Reflux	☐ Yes	☐ No	☐ Unsure
Hepatitis, Yellow Jaundice	☐ Yes	☐ No	☐ Unsure
Liver Problems	☐ Yes	☐ No	☐ Unsure
Bladder or Kidney Infections	☐ Yes	☐ No	☐ Unsure
Kidney Stones	☐ Yes	☐ No	☐ Unsure
Problem with Urination	☐ Yes	☐ No	☐ Unsure
Menstrual Problems	☐ Yes	☐ No	☐ Unsure
Infertility, Difficulty Getting Pregnant	☐ Yes	☐ No	☐ Unsure
Vaginal Infections	☐ Yes	☐ No	☐ Unsure
Herpes or A Partner With Herpes	☐ Yes	☐ No	☐ Unsure
Sexually Transmitted Disease	☐ Yes	☐ No	☐ Unsure
Pelvic Inflammatory Disease	☐ Yes	☐ No	☐ Unsure
Gonorrhea	☐ Yes	☐ No	☐ Unsure
Chlamydia	☐ Yes	☐ No	☐ Unsure
Syphilis	☐ Yes	☐ No	☐ Unsure
Genital Warts	☐ Yes	☐ No	☐ Unsure
HIV Infection, AIDS or a Partner with HIV/AIDS	☐ Yes	☐ No	☐ Unsure
Abnormal Pap Smear	☐ Yes	☐ No	☐ Unsure

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Diabetes (High Blood Sugars)	☐ Yes	☐ No	☐ Unsure
Thyroid Problems	☐ Yes	☐ No	☐ Unsure
Other Hormone Problems	☐ Yes	☐ No	☐ Unsure
Epilepsy, Seizure Disorder	☐ Yes	☐ No	☐ Unsure
Unexplained Drowsiness	☐ Yes	☐ No	☐ Unsure
Migraine/Cluster Headaches	☐ Yes	☐ No	☐ Unsure
Other Recurring Headaches	☐ Yes	☐ No	☐ Unsure
Depression	☐ Yes	☐ No	☐ Unsure
Panic Attack Disorder	☐ Yes	☐ No	☐ Unsure
Psychiatric/Mental/Emotional Problems	☐ Yes	☐ No	☐ Unsure
Skin Problems	☐ Yes	☐ No	☐ Unsure
Unexplained Hair Loss	☐ Yes	☐ No	☐ Unsure
Arthritis/Joint Pains	☐ Yes	☐ No	☐ Unsure
Lupus	☐ Yes	☐ No	☐ Unsure
Rheumatic Fever	☐ Yes	☐ No	☐ Unsure
Blood Transfusions	☐ Yes	☐ No	☐ Unsure
Bleeding Tendency	☐ Yes	☐ No	☐ Unsure
Blood Clots, Thrombophlebitis	☐ Yes	☐ No	☐ Unsure
Rh Sensitized	☐ Yes	☐ No	☐ Unsure
Do You Currently Smoke?	☐ Yes	☐ No	☐ Unsure
Any Past Surgeries (If yes please list below)	☐ Yes	☐ No	☐ Unsure
Any Known Drug Allergies?	☐ Yes	☐ No	☐ Unsure

Year	Type of Operation	Type of Anesthesia	Hospital/City	Surgeon
Example:				
1999	*Appendectomy*	*General*	*Good Sam/San Jose, CA*	*Smith*

Reviewed By_____

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Genetic/Family History

Please describe your ancestry: Please check all that apply

☐ White ☐ Guamanian ☐ Hawaiian ☐ Filipino ☐ Taiwanese
☐ African ☐ French Canadian ☐ Samoan ☐ Japanese ☐ Korean
☐ Hispanic ☐ Native American ☐ Chinese ☐ Laos ☐ Asian-East Indian
☐ Ashkenazi ☐ Greek ☐ Cambodian ☐ Vietnamese ☐ Middle Eastern
☐ Cajun ☐ Italian ☐ Other Southeast Asian ☐ Unknown Race ☐ Other_____

Are you and the father of this baby blood relatives (example: cousins)? ☐ Yes ☐ No

What is your occupation? _____

What is the Name of the Baby's Father_____ What is the age of the father of the baby? _____

What is the occupation of the father of the baby? _____

How would you describe the ancestry of the father of this baby? Please check all that apply

☐ White ☐ Guamanian ☐ Hawaiian ☐ Filipino ☐ Taiwanese
☐ African ☐ French Canadian ☐ Samoan ☐ Japanese ☐ Korean
☐ Hispanic ☐ Native American ☐ Chinese ☐ Laos ☐ Asian-East Indian
☐ Ashkenazi ☐ Greek ☐ Cambodian ☐ Vietnamese ☐ Middle Eastern
☐ Cajun ☐ Italian ☐ Other Southeast Asian ☐ Unknown Race ☐ Other_____

Is the father of this baby your partner? ☐ Yes ☐ No

Do you, the father of this baby, or any close relatives have:

Thalassemia (Greek, Mediterranean, or Asian Background)	☐ Yes	☐ No	Other inherited Genetic Disorder	☐ Yes	☐ No
Neural Tube Defect (Meningomyelocele Spina Bifida, of Anencephaly)	☐ Yes	☐ No	Maternal Metabolic Disorder (ex: Insulin-Dependent Diabetes, thyroid)	☐ Yes	☐ No
Congenital Heart Defect	☐ Yes	☐ No	Birth Defects	☐ Yes	☐ No
Down Syndrome	☐ Yes	☐ No	Recurrent Pregnancy loss, Stillbirth	☐ Yes	☐ No
Tay-Sachs (ex: Jewish, Cajun, French Canadian	☐ Yes	☐ No	Blindness or Deafness	☐ Yes	☐ No
Sickle Cell Disease	☐ Yes	☐ No	Bone or Skeletal Disorder (Dwarfism)	☐ Yes	☐ No
Hemophilia or Bleeding Problems	☐ Yes	☐ No	Breast, Ovarian, Colon Cancer	☐ Yes	☐ No
Muscular Dystrophy	☐ Yes	☐ No	Kidney Disorder	☐ Yes	☐ No
Cystic Fibrosis or Canavan Disease	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Mental Retardation/Autism	☐ Yes	☐ No	Blood Clots/Stroke	☐ Yes	☐ No
If Yes: Tested for Fragile X	☐ Yes	☐ No	Other_____		
Huntington Chorea	☐ Yes	☐ No			

Comments:_____
_____
_____

Rocky Mountain Perinatology
Care Agreement

After hours care:

- Urgent or Emergent care by Rocky Mountain Perinatology is available 24/7 on call.

Ultrasound

Ultrasound examination can detect many abnormalities, but some abnormalities are not detectable by ultrasound. You should realize that even with a complete ultrasound exam, we may be unable to find existing fetal abnormalities or those abnormalities that can appear later in the pregnancy or after birth. Findings on an ultrasound exam can be an indicator of potential chromosomal abnormalities but are not definitive. Currently, the only way to assess the baby's chromosomes with certainty is to actually obtain a sample of the baby's cells by amniocentesis, chorionic villus sampling, or fetal blood sampling.

Colorado Prescription Drug Monitoring Program

If you receive a prescription for a "controlled" (Schedule II through V) drug, your identifying prescription information will be entered into Colorado's electronic Prescription Drug Monitoring Program (PDMP) database when this drug is dispensed to you and may be accessed for limited purposes by specified individuals. You have a right to access your information in the PDMP through the Colorado Board of Pharmacy. You may seek corrections to the information as you would with your other medical records.

Privacy Practices:

I have been offered the opportunity to review, read and understand the RMP Notice of Privacy Practice.
I hereby consent that my health records may be disclosed to necessary parties for the purposes of my treatment, payment and health care services.
I understand I may revoke my consent at any time; however Rocky Mountain Perinatology is not required to accept my request. Revocation form must be completed and returned to RMP to be enforced and in effect the day it is received by RMP.

Financial Obligations:

I am obliged to understand, agree, and be financially responsible for services rendered to me by RMP providers.
I agree to pay my balance in full upon receipt of RMP Statement and letter, phone call, or text message requesting such payment.
I understand and agree that balances over 30 days old will incur a service charge and be considered past due.
I authorize the release of any information necessary to process my claims and irrevocably assign all benefits for claims to RMP.

_____ _____

Patient Signature Date

Sticker

Rocky Mountain Perinatology (RMP)

Consent for the Use or Disclosure of Protected Health Information (PHI)

I understand that as part of my healthcare, RMP originates and maintains health records describing my history, exam, tests results, diagnoses, treatments: past present and future; as well as costs, payments and adjustments by myself and my health plan.

I, _____, hereby consent to the use, access and disclosure of my PHI for the purposes of:

- planning my care and treatment, including other professionals and facilities that contribute to my care.
- communicating with other professionals who contribute to my care.
- evaluating care quality and professional competence.
- communicating appointments and/or balances on previously rendered and/or charged services for RMP provider and our agents and assigns.
- supplying diagnostic and procedural information to a third party for the processing of my services and bills related to my service.

I, _____, **hereby consent to the use, access and disclosure of my PHI to:**

☐ Spouse _____ ☐ Parent/Guardian_____

☐ Son/Daughter_____ ☐ Other_____

*By signing below, I understand and give my full consent to be contacted on the landline and/or cell phone number(s) provided to Rocky Mountain Perinatology and their assigns, including: appointments, test results, financial information, billing, and marketing material. This express authorization also applies to any landline or cell phone number(s) that I may acquire in the future. Rocky Mountain Perinatology and their assigns may also contact me by sending text messages or emails, using any e-mail address I may provide. *NOTE: Methods of contact may include using prerecorded/artificial voice messages and/or use of an automatic dialing device, as applicable. Providing your phone number(s) is not a condition of receiving services.*

I understand:

- I may request restriction on the uses and disclosures of my **PHI** at any time by completing and signing a restriction request form. I understand that RMP is not required to accept my restriction request.
- I understand I may revoke this consent at any time by signing a revocation form and returning it to the Medical Records Department at RMP. I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this consent.

My signature below acknowledges that I have read and understand and consent to RMP privacy and disclosure practices.

_____ _____

Signature Date

Rocky Mountain Perinatology

1107 S Lemay Ave, Suite 410 •Fort Collins, Colorado •80524
Telephone 970/294-4464, •Fax 970/482-1973
www.rmperinatology.com

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT NAME:_____ FORMER NAME: _____
BIRTHDATE:_____ SOCIAL SECURITY NO.:_____
CURRENT ADDRESS:_____ PHONE:_____
_____

THIS AUTHORIZATION APPLIES TO THE FOLLOWING INFORMATION:

□ Complete Health Record	□ Diagnosis and treatment codes	□ Discharge summary
□ Last 2 years of Health Record	□ Consultation reports	□ Progress notes
□ History and physical exam	□ X-ray reports	□ X-ray films / images
□ Laboratory test results	□ Complete billing record	□ Itemized bill
□ Photographs, U/S	□ Other, please specify:_____	

□ **EXCLUDE INFORMATION RELATING TO**:_____

PURPOSE OF REQUEST:

□ Treatment or consultation	□ At the request of the patient	□ Billing or claims payment
Date of Appointment: _____	□ Transfer of care	□ Litigation
□ Disability: (circle) Surgery / Pregnancy	Dates of disability period _____	□ Other: _____

I understand that these records may contain information regarding the **diagnosis or treatment of HIV (AIDS virus), other sexually transmitted diseases, drug and/or alcohol abuse or treatment, mental illness, psychiatric treatment or Hepatitis B or C testing. I give my specific authorization for these records to be released**. Initial if you decline_____ the release of these specific records.

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer at Rocky Mountain Perinatology, 1107 S. Lemay Ave., Suite 140, Fort Collins, CO 80524. Unless revoked, this authorization will expire 90 days from the date of signature.

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Reliability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form. I can view or receive a copy of the protected health information to be used or disclosed. **I authorize Rocky Mountain Perinatology to use and/or disclose the protected health information specified above.**

There is a charge for copies of records from Rocky Mountain Perinatology. The charge for records is $14.00 for the 1st 10 pages, then $0.50/page for pages 11-40, and $0.33/page for pages 41 and above. This charge is for patients and personal representatives under the HIPAA Privacy Rule. The Colorado Medical Society Standard is applied to all other parties. You will receive an invoice for this service from either Rocky Mountain Perinatology or HEALTHPORT.

_____ REQUEST FOR MEDICAL INFORMATION
(records from another facility to send to RMP: 1107 S Lemay Ave, Ste 410, Ft. Collins CO 80524)
From Doctor: _____
Address: _____
City/State: _____
Phone: _____
Fax: _____

_____ AUTHORIZATION TO RELEASE
(for RMP, 1107 S Lemay Ave, Ste 410, Ft. Collins, CO 80524 to send to another facility, as follows)
Send To: _____
Address: _____
City/State: _____
Phone: _____
Fax: _____

_____ _____
SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE **DATE SIGNED**

_____
WITNESS