AMOMI (Scottsdale Perinatal Associates, PLLC)

SERVICE REQUEST FORM

Office: 480-970-7664 Fax: 480-970-1907 Online: www.amomispa.com

Request Date: _____	Patient Name: _____
Requesting MD/DO: _____	Patient DOB: ____/____/_____
When Needed: (Circle one)	Patient Phone #: (____)_____
ROUTINE ASAP (< 3 days) TODAY	LMP: ___/____/_____ EDD:____/____/_____
Received:	Insurance:

CONSULTATIONS	**REASON** (choose one or more):
RECORDS ARE REQUIRED BEFORE SCHEDULING	o AMA
☐ Pre-Conception Consultation	o Diabetes
☐ Perinatal Consultation	o Hypertension
☐ Transfer of care (pending approval)	o Multiple gestation - Fetal # _____
☐ Diabetes Education (Bethany King, NP)	o Current PTL or short cervix
	o Medication Exposure
Physician Requested:	(specify): _____
☐ Earliest available consultation	o Abnormal US Findings:
☐ Karrie Francois, MD	(specify): _____
☐ Cathleen Harris, MD, MPH	o Family History: _____
☐ Joshua Makhoul, MD	o Other (specify): _____

1st TRIMESTER ULTRASOUNDS	**REASON** (choose one or more):
☐ Complete 1st Trimester Ultrasound	o Confirm viability and EDD
☐ Nuchal Translucency	o Evaluate vaginal bleeding or pain
☐ Limited US (fetal cardiac activity)	o Multiple gestation - Fetal # _____
	o Other: _____

2nd/3rd TRIMESTER ULTRASOUNDS (ROUTINE)	**REASON** (choose one or more):
☐ Complete OB ultrasound	o Fetal anatomy screen
☐ Follow up Complete OB ultrasound	o Follow up for fetal growth

2nd/3rd TRIMESTER ULTRASOUNDS (w/INDICATIONS)	**REASON** (choose one or more):
☐ Detailed/Targeted OB ultrasound	o AMA
☐ Fetal Echocardigram (including F/U)	o Suspected problem with fetal growth
☐ Follow up Complete OB ultrasound	o Suspected problem with placenta/fluid
☐ Transvaginal US Cervical Length	o Risk of PTL/evaluate cervix length
☐ Limited US (AFI or presentatation)	o Multiple Gestation - Fetal # _____
	o Medication Exposure
PLEASE SEND GENETIC SCREENING RESULTS & ULTRASOUND REPORTS for AMA or ABNORMAL U/S	(specify): _____
	o Abnormal US Findings:
	(specify): _____
	o Family History: _____
	o Other: _____

ANTEPARTUM FETAL TESTING	**REASON** (choose one or more):
Please circle *RECURRING YES or NO*	o AMA
☐ NST **___ times per week**	o Diabetes
☐ Biophysical Profile **___ times per week**	o Hypertension
☐ Umbilical Artery Doppler	o Multiple gestation - Fetal # _____
☐ MCA Doppler	o Other: _____
☐ Limited US (AFI or presentatation)	

PROCEDURES	**REASON** (specify)
☐ Venipuncture for NIPT	o AMA
☐ Chorionic Villus Sampling	o Abnormal genetic screening results
☐ Genetic Amniocentesis	o Family History: _____
	o Other: _____

Revised February 22, 2022