AMOMI (Scottsdale Perinatal Associates, LLC)
SERVICE REQUEST FORM
Office: 480-970-7664   Fax: 480-970-1907

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 ☐ Pre-Conception Consultation ☐ Perinatal Consultation ☐ Transfer of care (pending approval) ☐ Diabetes Education *Physician Requested:* ☐ Earliest available consultation ☐ Karrie Francois, MD ☐ Cathleen Harris, MD, MPH	o AMA o Diabetes o Hypertension o Multiple gestation - Fetal # _____ o Current PTL or short cervix o Medication Exposure (specify): _____ o Abnormal US Findings: (specify): _____ o Family History: _____ o Other (specify): _____

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

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

2nd/3rd TRIMESTER ULTRASOUNDS (w/INDICATIONS)	REASON (choose one or more):
☐ Detailed/Targeted OB ultrasound ☐ Fetal Echocardigram (including F/U) ☐ Follow up Complete OB ultrasound ☐ Transvaginal US Cervical Length ☐ Limited US (AFI or presentatation) *PLEASE SEND GENETIC SCREENING RESULTS & ULTRASOUND REPORTS for AMA or ABNORMAL U/S*	o AMA o Suspected problem with fetal growth o Suspected problem with placenta/fluid o Risk of PTL/evaluate cervix length o Multiple Gestation - Fetal # _____ o Medication Exposure (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* ☐ NST ___ **times per week** ☐ Biophysical Profile ___ **times per week** ☐ Umbilical Artery Doppler ☐ MCA Doppler ☐ Limited US (AFI or presentatation)	o AMA o Diabetes o Hypertension o Multiple gestation - Fetal # _____ o Other: _____

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

Revised January 2026