CENTER FOR MATERNAL FETAL CARE

Cone Health MedCenter for Women
930 Third Street
Greensboro, NC 27405

SCHEDULING LINE: (336) 890-3255 ~ ~ ~ **PLEASE FAX FORM AT TIME OF SCHEDULING TO (336) 890-3298**

PATIENT NAME: _____ **Date of Birth:** _____

REQUESTING PHYSICIAN: _____ **APPOINTMENT DATE/TIME:** _____

EDD:_____ □ **LMP** Date: _____ □ **Early U/S Date**: _____**EGA**_____ **Multiple Gestation:** □ **YES** □ **NO**

Insurance Pre-Authorization# _____ **Given by:** _____

☐ **ULTRASOUND (MD CONSULT AS INDICATED)** ☐ **MFM CONSULT ONLY**

INDICATIONS: _____
_____

☐ **GENETIC COUNSELING**

INDICATIONS: _____
_____

ANTENATAL TESTING:

____**FETAL NON-STRESS TEST (59025)**
____ **BIOPHYSICAL PROFILE WITHOUT NST (76819)**
____ **BIOPHYSICAL PROFILE WITH NST (76818)**

FIRST TRIMESTER ULTRASOUND:

_____ **OB COMPLETE < 14 WK ANATOMY US (76801)**
_____ **OB TRANSVAGINAL (76817)**
_____ **NUCHAL TRANSLUCENCY (76813)**
_____**OB LIMITED (NO MEASUREMENTS) 76815**

SECOND and THIRD TRIMESTER ULTRASOUND:

____**OB + 14 ANATOMY (76805) #FETUS**_____
____ **OB + 14 DETAIL ANATOMY (76811) #FETUS**_____
____ **OB FOLLOW-UP (76816) #FETUS**_____
____ **OB LIMITED (NO MEASUREMENTS) (76815)**
____ **OB TRANSVAGINAL (76817)**
____ **FETAL UMBILICAL ARTERY DOPPLER (76820)**
____ **FETAL MIDDLE CEREBRAL ARTERY DOPPLER (76821)**

PROCEDURES:

____ **AMNIOCENTESIS (76946)**
____ **CHORIONIC VILLUS SAMPLING**

PLEASE COMPLETE THE FOLLOWING:

Indication(s) for exam(s):_____

_____**ICD 10 Code(s):** _____

_____**DATE:** _____

PROVIDER SIGNATURE (Required)