Place this form on your High Risk Specialist Letterhead

REFERRAL RESPONSE

DATE:____________________________

NAME:_______________________________________ DOB:______________________

COUNTY OF RESIDENCE:_______________________ SS #:_____________________

REFERRING MD:______________________________ COUNTY:___________________

The above patient was seen in one of the Following Maternal-Fetal Medicine Clinics:	The following recommendation for the patient's care was made:
❑ High Risk Referral Clinic	❑ Return to primary care physician with recommendations
❑ Fetal Diagnostic Clinic	❑ Share care with high risk provider – deliver in home county
❑ Maternal-Fetal Medicine Clinic	❑ Share care with high risk provider – deliver at USACW
❑ Genetics	❑ Primary care with high risk provider – deliver at USACW

Patient status update:____

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High Risk Specialist:_______________________ Signature:_______________________

Cc: Gift of Life – Fax: 334-272-4614