

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:

- High Risk Referral Clinic
- Fetal Diagnostic Clinic
- Maternal-Fetal Medicine Clinic
- Genetics

The following recommendation for the patient's care was made:

- Return to primary care physician with recommendations
- Share care with high risk provider – deliver in home county
- Share care with high risk provider – deliver at UAB
- Primary care with high risk provider – deliver at UAB

Patient status update: _____

High Risk Specialist: _____ Signature: _____

Cc: Gift of Life – Fax: 334-272-4614