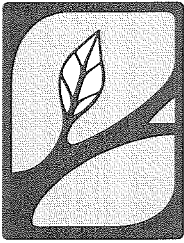

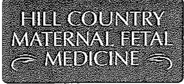

Request for Services

Celeste Sheppard, MD
4100 Duval Road, Building II, Suite 201
Austin, Texas 78759
512-339-1010 www.hcmfm.com fax 512-339-1011

Patient Information

Date:________________________

Name:____ DOB__________________________

Phone: home___________________ work___________________ cell____________________

Insurance____ ID#__________________________

Referring Provider_______________ phone/cell/beeper______________ FAX_______________

LMP:____________________ EDC:____________________ by scan on_________ @___________
Please send records of previous ultrasound examinations. Date EGA or CRL

Ultrasound examinations/procedures with consultation as indicated:

__Complete targeted fetal survey (18-20 weeks)
Indication: __increased aneuploidy risk
__increased NTD risk
__genetic scan
__suspected abnormality:
__other:

__First trimester risk assessment
(UltraScreen, 11-13 6/7 weeks)

__Fetal echocardiography. Indication:

__First trimester dating or visibility scan
__Basic 2nd / 3rd trimester exam (76805)
__Growth, EFW, or repeat evaluation
__Size greater or less than dates
__Breech/abnormal presentation
__Placental location or abnormality
__Other:

__Preterm delivery risk / cervical length
__Amniocentesis __CVS
__Multiple gestation: Twins/Triplets

Consultation and fetal assessment:

__Maternal medical condition:

__Obstetric complications:

__Diabetes, GDM with co-management

__DM, GDM without co-management

Fetal testing:

__Biophysical profile __NST/AFI
Indication:

__Amniocentesis for lung maturity
(date:)

Consultation only:

__Prepregnancy consultation for:

__Other

Additional information/comments:

Appointment Date:____________________ Time:_____________ Authorization#____________

Please fax the **prenatal record, maternal blood tpe** and **pertinent test results** for all consultations in order for us to see your patient. Thank you!