OSF HEALTHCARE

OSF Maternal Fetal Order Form

Office (309) 624-7811 Fax (309) 624-7734

USE THIS FORM FOR LOW-RISK PATIENTS OR THOSE WHO DECLINE MFM CONSULT

Patient Information

Last Name: _____ First Name: _____ MI: _____

DOB: _____ Pre-Pregnancy BMI: _____ SSN: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Interpreter Needed?: ☐ No ☐ Yes What language? _____

Assistive Needs: _____

Payor Information – Attach Copy of Insurance Card

Insurance Carrier (Name & Plan) _____

Policy ID: _____ Group # _____

Name of Policy Holder: _____

Relationship to Insured: _____

Select preferred patient location:

Main Location:

☐ Peoria

Satellite Clinics:

☐ Bloomington
☐ Galesburg
☐ Moline
☐ Peru

*We will make every effort to schedule your patient at their preferred location, However, due to limited availability at our satellite clinics, the patient may need to be seen in Peoria to ensure timely scheduling.

Please fax records and referral to (309) 624-7734.

Gravida:	Para:	Gestational Age:	LMP:	Initial USN:	Final EDC:

Cell Free DNA Testing (NIPT): ☐ Patient Declined ☐ Completed (fax results) ☐ Scheduled for: _____

Referral For: ☐ Singleton ☐ Twins ☐ Triplets ☐ Non-Pregnant

Ultrasound/Procedure Requested:

☐ Biophysical Profile 76819

☐ FAS 76805 US OB Complete 14+ weeks (LEVEL 2)

☐ FAS 76811 US OB Complete + Detailed Anatomy (LEVEL 3)

☐ Fetal Growth Ultrasound 76816

☐ Follow up US 76816 (if anatomy cannot be cleared on 1st visit)

***If you are not sure which study is indicated for your patient, please contact our office in advance for guidance**

Please provide all past and current perinatal records relevant to the referral prior to the patient's scheduled appointment. Supplying these records in advance will enable our providers to conduct a more comprehensive consultation.

**We are unable to process any referral without all information completed, including legible copies of the patient's insurance card and referring provider's name.

*****Please fax records and referral to (309) 624-7734.***

Referring Office Information

Referring Provider: _____Office Contact Person: _____ Phone: _____

Referring Provider Signature **(REQUIRED):** _____ Date: _____ Fax: _____

REQUIRED INFORMATION TO INCLUDE WITH REFERRAL:	SPECIALIST OFFICE USE ONLY
☐ Recent lab work ☐ Pertinent physician notes ☐ Specialty pertinent Information ☐ Dating ultrasound ☐ Current medications (including OTC and herbals) ☐ Allergies ☐ Pertinent summary/problem list	Patient scheduled week of: _____ Appointment with: _____

Updated 4.2026