Strong Perinatal Associates
500 Red Creek Drive, Suite 210
Rochester NY, 14623
Ph: 585-487-3350
Fax: 585-334-0699

Patient: _____ Date of Birth: ___/___/_____

Date Called/Faxed on: ___/___/_____
Referring Provider: _____
Address: _____
Contact person: _____
Office contact direct line: _____
Fax: _____

Does the patient speak and read English? Yes No Language: _____

Gravida: _____ Para: _____
EDC: ___/___/_____ LMP: ___/___/_____

Referral Type:

- ☐ Management consultation
- ☐ Consultation with Ultrasound
- ☐ Co-management
- ☐ Transfer of prenatal care
- ☐ Preconception consultation

Indication for Consult:

- ☐ Maternal Condition: _____

- ☐ Fetal Condition (usually requires ultrasound): _____

****Advanced maternal age, abnormal first/second trimester screen, family history of genetic disease, and patients with ultrasound findings suggestive of aneuploidy should go to Reproductive Genetics, Fax: 585-334-6292***

Please complete checklist to facilitate your patient's referral:

- ☐ Updated demographic sheet
- ☐ Confirmation of pregnancy (viability scan / dating ultrasound)
- ☐ All prenatal records
- ☐ All labs
- ☐ Pertinent Specialty notes/records ex: endocrinology, cardiology, prior deliveries

Include patient's completed release of information forms for all facilities and records related to this referral

Upon receipt of completed referral, our clinical team will review to determine patient's needs within 3-5 business days. Our staff will call patient to schedule according to recommendations.
Note additional urgency here: _____