SILICON VALLEY
Maternal-Fetal Medicine

14880 Los Gatos Blvd, Second Floor, Los Gatos, CA 95032

REFERRAL FORM (First Visits Starting June 10, 2025)

Please FAX to (408) 608-1620 or email to hello@svmfm.health

*Required

Patient Information:

First Name*:_____ Middle Name:_____
Last Name(s)*:_____
DOB*:_____ Phone*:_____
Alternate Phone: _____ Email*:_____
Insurance*:_____
Indication*:_____

*If pregnant**:
Patient due date (EDD):_____
LMP:_____
Dating U/S: date of scan and U/S gestational age on date of scan:
_____

Referring Provider Information:

Referring Clinic*:_____ Clinic Phone*:_____
Referring Provider Name*:_____Provider Phone:_____

Service(s) Requested* (Please check off at least one service):

Ultrasound
- ☐ First trimester viability and dating
- ☐ First trimester anatomy scan/NT
- ☐ Detailed anatomy scan
- ☐ Fetal echocardiogram
- ☐ Growth scan with Doppler studies as indicated
- ☐ Biophysical profile
- ☐ Transvaginal ultrasound scan
- ☐ Gynecologic scan (uterus, cervix, adnexa)

Diabetes Care
- ☐ Gestational diabetes
  - ☐ 1hr GCT result: _____
  - ☐ 3hr GTT result: _____
  - ☐ 2hr GTT result: _____
- ☐ Type 1 DM
- ☐ Type 2 DM

MFM Consult
- ☐ Medical complication of pregnancy including pre-existing conditions (e.g., gestational HTN, preeclampsia, chronic HTN, thyroid disease, lupus, depression, obesity); specify: _____
- ☐ Pre-conception
- ☐ Postpartum
- ☐ Currently pregnant with prior obstetrical complication; specify: _____
- ☐ Genetic consult