



El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

2485 Hospital Dr., Suite: 250
Mountain View, CA 94040
(650) 988-7930

**Attn: For all HMO patients
insurance authorization is
required prior to patient
scheduling an appointment*

PATIENT INFORMATION

Patient Name: _____
Birth Date: _____
Telephone No. _____
LMP: _____ EDC: _____
G ___ P ___ SAB ___ TAB ___
Twins: Yes / No

**El Camino Hospital/Stanford Prenatal Diagnostic Center
Physician Order Form**

Procedure:

- OB Ultrasound/Screening for Malformations/
- Amniocentesis (will include genetic counseling and ultrasound)
- Genetic Counseling
- Perinatal Consult for: _____
- Biophysical Physical Profile

- Nuchal Translucency/Please fax first trim. form
- Nuchal Translucency/ Please fax first trim. form (ultrasound with genetic counseling)

Did pt. have Cell Free DNA Test: yes or No
(If yes – Fax results please)

**CVS Procedures are now performed at ECH
Fax requests to (650) 988-7859**

- Chorionic Villus Sampling (CVS)
- Oligohydramnios
- Multiple gestation
- Gestational Diabetes
- Pre-gestational Diabetes
- Pregnancy-Induced Hypertension
- Pre-gestational Hypertension
- Non-reactive NST
- Prenatal Screening (e.g. NT)
- Ultrasound marker (CPC, IEF, Pelviectasis, etc.)
- Other _____

Reason for Procedure:

- Advanced Maternal Age
- Positive Prenatal Screen
- Family history of _____
- Previous history of _____
- Screening for malformations
- Size larger than dates
- Size smaller than dates
- Returning for: _____
- Polyhydramnios

Please Schedule the Ultrasound:

- At 18-20 weeks
- At 20-22 weeks
- At _____ weeks
- Within One Week
- Two Weeks
- When available

*Repeat ultrasound(s) as clinically indicated and recommended by the perinatologist

Location: El Camino Hospital/Stanford Prenatal Diagnostic Center 650-988-7930

Date _____ Time: _____ Physician Signature _____

Print Name _____

Please fax ALL prenatal labs, screening results (1st. trimester, AFP) and insurance information to
650-988-7859