**Date:** [Insert Date]

**To:** [Consultant Name/Maternal-Fetal Medicine Department]
**Address:** [Insert Address]
**Fax/Phone:** [Insert Contact Information]

**From:** [Referring Provider Name]
**Clinic:** [Insert Clinic Name]
**Contact:** [Insert Phone Number]

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**RE: High-Risk Pregnancy Consultation**

**Patient Name:** [Patient Full Name]
**Date of Birth:** [Patient DOB]
**Estimated Date of Delivery (EDD):** [Insert EDD]
**Gestational Age:** [Insert Weeks/Days]

**Reason for Referral:** High-risk obstetric consultation due to history of previous Cesarean Section(s).

**Clinical History:**

- **Gravida/Para:** G[ ] P[ ]
- **Number of Prior C-Sections:** [Insert Number]
- **Indication for Prior C-Section(s):** [e.g., Failure to progress, Breech, Fetal distress]
- **Type of Uterine Incision:** [e.g., Low transverse, Classical, Unknown]
- **Interval since last delivery:** [Insert Time]

**Requested Evaluation:**

- Assessment of candidacy for Trial of Labor After Cesarean (TOLAC) vs. Repeat Cesarean Delivery.
- Ultrasound evaluation for placental location and potential accreta spectrum (if indicated).
- Co-management or transfer of care recommendations.

**Current Medications/Allergies:**
[Insert List]

**Attached Documentation:**
[ ] Previous Operative Reports
[ ] Current Prenatal Records
[ ] Recent Ultrasound Reports

Thank you for your assistance in evaluating this patient.

Sincerely,

[Signature]
[Printed Name and Credentials]