

URGENT REFERRAL

Date: [Insert Date]

To: [Specialist Name/Clinic Name]

Department: Maternal-Fetal Medicine / Obstetrics & Gynecology

Fax/Phone: [Insert Contact Info]

From: [Referring Physician Name]

Clinic: [Clinic/Facility Name]

Contact: [Phone Number]

PATIENT DETAILS:

Name: [Patient Full Name]

Date of Birth: [DOB]

Gestational Age: [Number] Weeks [Number] Days (EDD: [Date])

Gravity/Parity: G[#] P[#]

REASON FOR URGENT REFERRAL:

[Insert primary diagnosis or acute concern, e.g., Preeclampsia, Abnormal Anatomy Scan, Fetal Growth Restriction, etc.]

CLINICAL FINDINGS & SYMPTOMS:

[Briefly describe recent symptoms, blood pressure readings, or physical exam findings.]

RELEVANT TEST RESULTS:

- **Ultrasound:** [Insert key findings]
- **Lab Work:** [Insert critical values]
- **Other:** [NIPT, Glucose Screen, etc.]

REQUESTED ACTION:

- Urgent Consultation & Management
- Targeted Ultrasound/Biophysical Profile
- Amniocentesis/CVS
- Transfer of Care

COMMENTS:

[Insert any additional notes or specific questions for the specialist.]

Sincerely,

[Signature]

[Printed Name and Credentials]

[NPI Number]