Request for Perinatal Substance Use Clinic

MAHEC OB/GYN Specialists
119 Hendersonville Road • Asheville, NC 28803
Tel: (828) 771-5529 • Fax: (828) 771-5479
Provider consult line: (828) 771-5542

Clinical Information

Blood type: _____

LMP: _____

FINAL EDC: _____

By LMP: _____ By US: _____

High Risk Ob/Gyn Care with Substance Use

Four options for care (circle one):

1. Consultation for maternal substance use exposure and post-delivery planning/education

   ☐ With Ultrasound
   ☐ Without Ultrasound

2. New or Transfer of OB Care for maternal opioid substance use

   Is the patient on (check one):

   ☐ Methadone or
   ☐ Buprenorphine
   ☐ Suboxone or ☐ Subutex

   Is the patient interested in learning more about buprenorphine treatment?

   ☐ Yes ☐ No ☐ Unknown

3. New or Transfer of OB Care for maternal other substance use (e.g. alcohol, THC, cocaine, methamphetamines, etc.)

4. New or transfer of care for parenting patient for maternal substance use (OUD or other substances)

Other high-risk diagnosis?

_____

_____

_____

PATIENT INFORMATION

Date: _____

Name as it appears on insurance: _____

DOB: _____ SSN: _____

Address: _____

_____

Contact Phone: _____ Alternate Phone: _____

Is an interpreter needed? ☐ Y ☐ N If Yes, language: _____

INSURANCE INFORMATION (Attach copy of card)

☐ Medicaid ☐ Medicare ☐ Self-Pay ☐ Commercial: _____

Member ID Number: _____

REQUESTING PROVIDER

Name: _____

Practice: _____ Physician NPI #: _____

Phone: _____ Fax: _____

Office Contact: _____

After Hours Emergency Contact: _____

REQUESTED DOCUMENTATION

***To process this referral, the following documentation is required:**

- Prenatal/Medical Records, including blood type
- Harmony/Quad Screen Results/Ultrasound Results, if applicable

(Results not available at time of referral must be sent prior to appointment.)

Note: Please allow 2 business days from receipt of requested records for notification of appointment time.

By scheduling this referral, you are requesting that Maternal Fetal Medicine perform additional ultrasound procedures as clinically indicated and/or consultation as appropriate for your patient.

APPOINTMENT INFO:

Date: _____ Time: _____ Scheduler's Initials: _____

Given to: _____ Date: _____ Scheduler's Initials: _____