



REFERRAL FORM

Fax (all locations): (858) 939-6808

Please advise your patients that we will contact them to schedule an appointment once we have received the referral and authorization from your office.



CHOOSE OFFICE LOCATION:

- San Diego Perinatal Center**
8010 Frost Street, Suite 300
San Diego, CA 92123
Main Phone: (858) 939-6880
- Temecula Valley Perinatal Center**
25485 Medical Center Dr, Suite 100
Murrieta, CA 92562
Main Phone: (951) 690-1640
- Encinitas Perinatal Center**
1130 2nd Street
Encinitas, CA 92024
Main Phone: (760) 943-0279

SERVICES REQUESTING:

- Comprehensive Ultrasound and Consult***
Level II, Targeted, Maternal Fetal Evaluation, Genetic, AMA, CPT codes 76811+99244
Twins add CPT codes 76812 + 76817
- Routine Ultrasound and Consult***
Initial exam - CPT codes 76811 + 99244
Follow Up - CPT codes 76805 + 99244
Twins add CPT code 76810
- Fetal Echo and Consult*** - CPT codes 76811 + 76825 + 99244
- Amniocentesis or Other Genetic Testing**
CPT codes 76946 + 59000 + 76811
Amnio Lab Work-CPT codes 82106 + 88235 + 88267 + 88280 + 88291
- CVS - CPT codes 76801+76945+59015**
CVS Lab Work CPT codes 88235 + 88267 + 88280 + 88291
- Perinatal Consult**** - CPT code 99244
- AFP Program - Please have patient phone us when you have notified them of AFP results**
- Genetic Counseling**-CPT code 99244(i.e. AMA, anomalies, Teratogen Exposure)
- First Trimester Screening / Nuchal Translucency**
CPT codes 76801 + 99244 + 76813
Each additional fetus - CPT codes 76802 + 76814
Lab work - CPT codes 84163 + 84702
- Consideration for Transfer of Care**
- Diabetic Consult with Physician**
Please Schedule patient for Diabetic Education through Sharp Diabetes Program 858-939-5040 PRIOR TO VISIT
- Preconception Consult**

*Consults performed with ultrasound only if unexpected finding. **Check "Perinatal Consult" if known indication/abnormalities.

DATE: _____ REFERRING PHYSICIAN: _____
OFFICE NAME: _____ OFFICE ADDRESS: _____
OFFICE PHONE: _____
FAX RESULTS TO: _____
PATIENT NAME (PLEASE PRINT): _____ DOB: _____
PT CELL#: _____ HOME#: _____ WORK#: _____
ADDRESS: _____ SSN#: _____
DX: _____
EDC: _____ RH: _____ MCV: _____
INSURANCE CARRIER: _____ TYPE: HMO / PPO IPA: _____

AUTHORIZATION REQUIRED: YES / NO PLEASE ATTACH A COPY OF THE AUTHORIZATION

PLEASE FAX COPY OF INSURANCE CARD, AUTHORIZATIONS AND ANY RELEVANT MEDICAL RECORDS
Scheduling of appointment could be delayed if proper information is not received.

Drs Casele • Catanzarite • Cousins • Daneshmand • Dowling • Duerbeck