THE University of Vermont MEDICAL CENTER

Intake Form for Maternal Fetal Medicine

Please complete and fax to 802-847-2360

Medical Center Campus
East Pavilion – Level 4
111 Colchester Ave
Burlington, VT 05401
802-847-1400

Name:_____ D.O.B._____ MRN:_____
Phone: (H)_____ (W) _____
Address:_____
_____
Insurance:_____

Referring Provider: _____ PCP: _____
Gravida____Para_____EDC:_____LMP:_____

Service(s) Requested: Check ALL that apply

☐ **Initial Antepartum Visit:**
Reason:_____

☐ **Transfer of Care:**
Reason:_____

☐ **Consultation:**
Reason:_____

☐ **Diabetic Consult:**
Abnormal GTT: FBS: _____; 1 HR _____; 2 HR _____; 3 HR _____
Comments:_____

☐ **Nutrition Consult:**
Reason:_____

Please send ALL patient records with intake form

Contact Name: _____Phone #:_____Fax #:_____
Appointment Date: _____Appointment Time: _____

MFM USE ONLY:

OFFICE OR PATIENT CONTACTED (CIRCLE ONE) DATE: ___/___/_____