High Risk Obstetrical Consultants
Not your average pregnancy.

REFERRING PROVIDER FORM

Thank you for trusting HiROC to be part of your patient's care team. Please use this form to provide the initial information our office needs to start the process of scheduling your patient's appointment(s).

Referring provider: _____
(include office name) _____

Phone Number: _____

Patient's Name: _____ Date of Birth: _____

Patient's Insurance: _____

Dating from latest ultrasound: Weeks _____ / Days _____

Reason for referral

- ☐ Advanced maternal age
- ☐ Suspected fetal anomaly
- ☐ Maternal medical condition
  Please specify: _____
  _____
- ☐ Multi-fetal pregnancy
- ☐ Cervical insufficiency
- ☐ Prior preterm birth
- ☐ Recurrent miscarriage
- ☐ Other (please specify)
  _____
  _____
  _____

Once completed, please fax this form along with patient demographics and medical records to (865) 263-2401. If you have any questions, please call our office at (865) 263-2400. Again, thank you for the opportunity to care for your patient.