YES! We are open Saturdays & Extended hours upon request.

Consultation:

☐ Consult (With Ultrasound if Needed)

Ultrasound:

☐ First Trimester Ultrasound
☐ Second Trimester Ultrasound
☐ Ultrasound with Dopplers
☐ Biophysical Profile w/o NST
☐ Other: ___________________

Screening:

☐ Aneuploidy Screening (With Ultrasound if Needed)
☐ Genetic Screening (With Ultrasound if Needed)

Information Required:
Please fax the following information with this form:

1. Prenatal Records
2. Lab Reports (Prenatal Profile, Quad Screen, Glucose Testing, & Blood Type)
3. Dating Criteria & Relevant Ultrasound Reports
4. Insurance Authorizations

FOR SUNSHINE PERINATOLOGY OFFICE USE ONLY:
MRN#________________________

LAMA TOLAYMAT MD MPH FACOG

The first independent female Perinatologist in Central Florida

2310 North Boulevard West, Davenport, FL, 33837
Telephone: 863 852 1050
Fax: 863 353 6887
www.SunshinePerinatology.com
Email: office@sunshineperinatology.com

Request for Maternal-Fetal Medicine Services

Date: ________________

Patient Information:

Patient Name: ____

Patient DOB: _____/_____/_____ Contact Phone: ____________________________

Patient Insurance Information: *(Please attach copy of insurance card)*

Insurance Company: ____

Payer Name: ____

Subscriber Name: ____

Subscriber DOB: _____/_____/_____ Subscriber ID: ___________________________

Referral/Authorization (if necessary) ____

Referring Physician:

Physician Name: ____________________ Practice Name: _____________________

Practice Address: ____

City: __________________________________ Zip: ___________________________

Phone: _______-_________-_________ Ext.: _____ Fax: _______-_______-_______

Contact Person: ____

Clinical Indication for Services Requested: *(Refer to our common ICD-9 codes)*

ICD-9 Code: ____

LMP: _____/______/____________________ EDD: _____/______/____________________

Description: ____

____

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My team and I would like to thank you for your referrals and trust in our service!