CONSULT AND REFERRAL GUIDELINES

To support collaborative care, we have developed guidelines for our community partners to utilize when referring to, and managing patients with, the maternal fetal medicine specialists at OhioHealth.

OhioHealth Maternal Fetal Medicine accepts referrals via EPIC or fax. Please contact us by phone to make an urgent referral or if you have additional questions regarding these referral guidelines.

Phone: 614-566-4378 **Fax: 614-533-1216** **Epic Referral ID:** AMB Referral to Perinatology (REF86)

To schedule an appointment for your patient, we require the following records: history and physical exam, pregnancy progress notes, medication and allergy lists, all OB ultrasounds from the current pregnancy, and routine prenatal labs. We may require additional records based on the referring diagnoses. We also request proof of viable pregnancy. If a patient has not had an early ultrasound, a consistent exam and positive fetal heart tone is sufficient.

VISIT TYPE DEFINITIONS

Physician Evaluation and Management: This visit is completed with every ultrasound done in MFM. It consists of an ultrasound accompanied with a brief discussion with an MFM physician to review any findings and recommendations. *Patients referred for most ultrasound-based finding will have a Physician Evaluation and Management instead of a consultation.*

Physician Consult: Detailed review of patient's medical history with written recommendations regarding diagnosis and treatment. Patient's visit may include seeing a MFM APP for initial evaluation prior to the physician's assessment. *Consults are recommended for patients with a problem in a prior pregnancy – prior fetal condition, prior maternal condition, or prior obstetric complication.*

Genetics Consult: This visit type is a prescheduled appointment that includes meeting with a genetic counselor either in person or by telehealth. It could also include testing options completed by bloodwork or procedure in office.

CLINICAL TIMING

Appointment Type	Scheduling Range
Anatomy/Level II	Scheduled 18 weeks or greater
Fetal Echo	Scheduled 22 – 26 weeks
Chorionic Villi Sampling (CVS)	Scheduled 11-14 weeks
Amniocentesis (Amnio)	Scheduled at 16-24 weeks
Nuchal translucency (NT)	Scheduled 11.2 – 13.6
Cell Free DNA	Scheduled 10 weeks or greater
Preconception Consult Non-Pregnant	Scheduled 1st and 3rd Thursday afternoons at RMH either in person or telehealth.

REFERRAL PROCESS

STEP 1

Below is a list of pregnancy complications addressed by our MFM specialists. Check the condition for guidance on timing of referral, required information, and services offered.

Step 2

Please indicate if referral is urgent or routine. The referral will be triaged by the MFM team according to clinical guidelines. If your request is urgent – please place the referral. Once you place, please reach out to our office to speak to one of our referral coordinators to assist with handling.

Step 3

Patients with urgent conditions are scheduled to be seen as soon as possible (typically within 7 days or per clinical guidelines for gestational age). Our team will reach out to the patient to schedule. If the patient is not responsive to our attempts – we will send both the patient and the referring provider a letter.

Diagnosis / Symptom	When to initiate referral:	Referring provider's initial evaluation/management and information to send with the referral	MFM visit will likely include:
OBSTETRIC COMPLICATIONS			
Amniotic Fluid Abnormalities	When Identified	• Detailed OB history and prenatal records • Reports from all OB ultrasounds • Labs: if polyhydramnios include 1 hr. GTT result if it has been done, aneuploidy screening if available.	• Ultrasound • Physician Evaluation and Management
Consanguinity (related by blood ex: cousins)	1st Trimester	• Detailed OB history and prenatal records • Reports from all OB ultrasounds	• Ultrasound • Physician Evaluation and Management • Genetic Consultation
History of cervical insufficiency	1st trimester or preconception	• Detailed OB history • Records (prenatal records and delivery) from prior pregnancy (ies) with second trimester loss • Reports of prior pregnancy OB ultrasounds if available • Operative notes from prior cerclage (if done) • Placenta reports (including cultures and/or cytogenetics if available)	• Possible Physician Consult between 11- 12 weeks • Cervical Length Ultrasound between 14 – 16 weeks • Physician Evaluation and Management
History of preterm delivery	Prior to 16 weeks or preconception	• Detailed OB history • Records (prenatal records and delivery) from prior pregnancy (ies) • Delivery records (showing indication or etiology)	• Physician Evaluation and Management • Ultrasound for anatomy/growth and cervical length
History of 2nd or 3rd trimester IUFD	1st trimester or preconception	If available: • OB Ultrasounds and prenatal records from prior pregnancy • Autopsy report • Delivery records • Placenta report • Cytogenetics results	• Physician Evaluation and Management • Ultrasound for anatomy/growth

Diagnosis / Symptom	When to initiate referral:	Referring provider's initial evaluation/management and information to send with the referral	MFM visit will likely include:
Molar pregnancy	When identified	• Prenatal records • All ultrasound reports	• Physician Evaluation and Management • Ultrasound for anatomy/growth
Preeclampsia	When identified	• Prenatal records include BP readings • Labs done prior to the appointment if available • Hospitalizations records (if applicable)	• Ultrasound for anatomy/growth • Physician Evaluation and Management
Placenta accreta, increta, percreta	When identified or suspected	• Detailed OB history • Delivery records • All ultrasound reports	• Physician Evaluation and Management • Ultrasound
Recurrent pregnancy loss	1st trimester or preconception	• Detailed OB history and prenatal records from prior pregnancies • Laboratory panel results • Karyotype testing on parents (if done) • Hysterosalpingogram, hysteroscopy or other testing (if done)	• Physician Evaluation and Management • Genetic counseling • Consider referral to Reproductive and Endocrinology
Second or third trimester vaginal bleeding	When identified	• Detailed OB history and prenatal records • All ultrasound reports (if done)	• Physician Evaluation and Management • Ultrasound for anatomy/growth and cervical length •
Short cervix	Urgent referral If < 20 mm at < 24 weeks and no history of preterm birth or If < 24 weeks with history of preterm delivery	• Detailed OB history • Prenatal records • Reports from all OB ultrasounds	• Ultrasound for anatomy/growth and cervical length • Physician Evaluation and Management

Diagnosis / Symptom	When to initiate referral:	Referring provider's initial evaluation/management and information to send with the referral	MFM visit will likely include:
Maternal Complications			
Advanced maternal age (≥ 35 years old at age of delivery)	1st trimester- if patient desires sequential screen, the appointment must be between 10 weeks & 3 days and 13 weeks & 6 days	• Confirm age at EDC > 35 years • Initial ultrasound report to confirm dating	• Physician Evaluation and Management • Genetic Counseling to review testing options • NT if 1st trimester and sequential screen desired • Detailed anatomy ultrasound at 18-20 weeks
Cardiac Disease (congenital heart disease, arrhythmias, valve disease, cardiomyopathy, pulmonary hypertension, coronary artery disease, heart transplant)	1st trimester or preconception	• Determine the cardiac diagnosis and request historical records • Cardiology consult notes • Most recent EKG and echocardiograms available • Operative notes and discharge summaries for any cardiac procedures	• Physician Evaluation and Management • Detailed anatomy ultrasound at 18-20 weeks • Fetal echo at 22-26 weeks (if applicable) • Possible referral to adult congenital cardiac disease program
Chronic Hypertension	Preconception and/or 1st trimester	• How long has the patient had chronic HYPERTENSION and has she ever had a workup including EKG, ECHO, renal artery Doppler? • Past records regarding management of HYPERTENSION • Labs: CBC, CMP, protein/creatinine, 24-hour urine for protein	• Physician Evaluation • Ultrasound for anatomy/serial growth • Low dose aspirin if no allergy (between 13-16 weeks) • Lab orders, if not performed • Serial growth ultrasound

Diagnosis / Symptom	When to initiate referral:	Referring provider's initial evaluation/management and information to send with the referral	MFM visit will likely include:
Diabetes, Pre-gestational	Preconception or 1st trimester	• Diagnosis: Type 1 or Type 2 and duration of disease • Labs: CBC, CMP, 24-hour urine or protein/creatinine ratio, HbA1c (preconception or early pregnancy), TSH/Free T4 • Notes from endocrinologist or family physician • Ophthalmology notes • Nephrology notes if applicable	• Physician Evaluation • Detailed anatomy ultrasound at 18-20 weeks • Serial ultrasounds for growth • Fetal echocardiogram at 22-26 weeks • Referral to Dietician
Diabetes, gestational	Within 1 week of diagnosis	• Glucose tolerance test results (abnormal 1 hr. and 3 hr. • Notes from diabetic education (if done)	• Physician Evaluation • Diabetes Education • Ultrasound for anatomy/growth at time of initial referral and serial ultrasounds for growth
Gastrointestinal disease (Hyperemesis Gravidarum, Crohn's disease, Ulcerative Colitis, Liver Disease, Liver Transplant, Gallbladder Disease)	1st trimester or preconception	• Define the diagnosis • Labs: CMP • Medications used	• Physician Evaluation and Management • Ultrasound for anatomy/ growth • Serial growth ultrasounds if indicated
Hematologic diseases (Hemoglobinopathies, sickle cell disease, TTP)	Depending on the condition: if preexisting, preconception, or 1st trimester. If acquired: when identified	• What testing has the patient had and how was the diagnosis made? • Labs: Hemoglobin electrophoresis results, CBC's • In case of thrombocytopenia, clarify if new or preexisting diagnosis and what work up has been done (e.g., ANA reflex, hematology, TORCH, etc.) • Hematology records if available	• Physician Evaluation • Ultrasound for anatomy/growth • Consider serial ultrasound for growth

Diagnosis / Symptom	When to initiate referral:	Referring provider's initial evaluation/management and information to send with the referral	MFM visit will likely include:
Gestational Thrombocytopenia	Preconception or when identified	• Referring Provider's initial evaluation, management and any genetic testing done for HPA-1 or through the Blood Center of Wisconsin	• Physician Consult • Detailed Anatomy Ultrasound
Neonatal Alloimmune Thrombocytopenia (NAIT)	Preconception or as early EGA as possible	• Referring provider's initial evaluation • Prior affected pregnancy's prenatal, neonatal, and pediatric records • Prior NAIT records of antibody testing (HPA-1) would be helpful • Recommend that the father of the baby also attend the consult as we may need labs on him	• Physician Consult • Ultrasound based on gestational age (i.e. <11 weeks: viability, 11-13 weeks NT scan, 14-18 weeks: follow-up scan/biometry, and 18-20 weeks: anatomy scan)
History of thrombosis and/or thrombophilia	Preconception or 1st trimester	• Does the patient have a history of thrombosis or how was the diagnosis made? • Hospital records regarding initial diagnosis and management • Hematology records • Lab results: Factor V Leiden, Prothrombin mutations, Protein S, C and ATIII, cardiolipin and beta glycoprotein, lupus anticoagulant	• Physician Evaluation and Management • Ultrasounds for anatomy/growth
History of surgery to the uterus or cervix	2nd trimester, 16-20 weeks	• Operative notes and discharge summary • Imaging of the cervix and/or uterus	• Physician Evaluation and Management • Ultrasounds for anatomy/growth
Infectious disease - (Cytomegalovirus, Hepatitis B or C, HIV, Zika, Varicella, Parvovirus, Rubella, Syphilis, Toxoplasmosis, Tuberculosis)	When identified	• How long has the patient had the disease, etiology? • Recent labs: serology, viral load, CBC, CMP • If patient has HIV and managed by ID. Records from ID visits, most recent viral load, and medication list.	• Physician Evaluation and Management • Ultrasound for anatomy/growth • Serial growth ultrasounds
In vitro fertilization (IVF) conception	18-20 weeks	• Records from reproductive endocrinology appointment	• Physician Evaluation and Management • Detailed anatomy ultrasound • Fetal echocardiogram at 22-26 weeks

			• Serial Growth Ultrasounds
Morbid Obesity (BMI 35 or greater)	18-20 weeks		• Detailed anatomy ultrasound
Neurologic disorders (Seizure Disorder, Multiple Sclerosis, etc)	Preconception or 1st trimester. If patient is teratogen referral as soon as pregnancy known, otherwise 18-20 weeks	• Neurology notes • Imaging- CT or MRI • EEG • Medication history and levels, if drawn	• Physician Evaluation • Detailed anatomy ultrasound • Serial Growth ultrasounds
Diagnosis / Symptom	**When to initiate referral:**	• **Referring provider's initial evaluation/management and information to send with the referral**	• **MFM visit will likely include:**
Psychiatric disorders (Schizophrenia, Bipolar disorder, Severe Refractory Depression, Exposure to Teratogenic psychotropic medications)	Preconception or 1st trimester. If patient is teratogen referral as soon as pregnancy known, otherwise 18-20 weeks	• Psychiatry notes	• Physician Evaluation and Management • Detailed anatomy ultrasound • Serial growth ultrasounds
Renal disease	1st trimester or preconception	• Define the diagnosis. How long has the patient had the disease? • Nephrology notes • Labs: ANA, CMP, urine protein testing	• Physician Evaluation and Management • Ultrasound for anatomy/growth • Serial growth ultrasounds
Respiratory disease (asthma, restrictive lung disease, cystic fibrosis)	1st trimester	• Pulmonology consult notes	• Physician Evaluation and Management • Ultrasound for anatomy/growth • Serial growth ultrasound if indicated
Rheumatologic disorders (Systemic Lupus Erythematous, Rheumatoid Arthritis, Vasculitis, Antiphospholipid Syndrome, etc)	1st trimester or preconception	• Rheumatology or Internal Medicine notes • Applicable labs (SSA/SSB antibodies, cardiolipin, lupus anticoagulant, beta 2 glycoprotein CMP, protein/creatinine ratio, DS DNA levels, C3 & C4, etc)	• Physician Evaluation and Management • Detailed anatomy ultrasound • Serial growth ultrasounds
Substance abuse	When identified	• Drug screens	• Physician Evaluation and Management • Detailed anatomy ultrasound • If the patient is on suboxone, will also need a referral to Community OB Clinic program at

			GMC or RMH for management and total care. • Serial growth ultrasounds
Thyroid dysfunction	2nd trimester 16-20 weeks	• Recent thyroid labs • Endocrinology notes	• Physician Evaluation and Management • Detailed anatomy ultrasound
Diagnosis / Symptom	**When to initiate referral:**	**Referring provider's initial evaluation/management and information to send with the referral**	**MFM visit will likely include:**
Fetal Anomalies			
Abnormal ultrasound findings: markers of aneuploidy or major structural malformations/anomalies	When identified	• OB history, family history and prenatal records • All ultrasound reports	• Physician Evaluation and Management • Detailed anatomy Ultrasound • Genetic counseling • Fetal echocardiogram if applicable • Coordination of care
Aneuploidy or increased risk for aneuploidy Abnormal maternal serum screening including serum analytes or cell free DNA) Increased AFP	Immediately following abnormal result	• Abnormal screening result • Earliest dating ultrasound and all additional ultrasound reports available	• Physician Evaluation and Management • Genetic counseling • Detailed anatomy ultrasound • Coordination of care • Serial Growth Ultrasound if Indicated
Increased MSAFP or increased risk of Open Spina Bifida	Immediately following abnormal result	• Abnormal screening result • All ultrasound reports	• Physician Evaluation and Management • Genetic Counseling • Detailed anatomy ultrasound
Fetal anatomy not well seen	When identified	• All ultrasound reports	• Detailed anatomy ultrasound • Physician Evaluation and Management
Teratogen exposure (such as alcohol, Depakote, phenytoin, Lamictal, antidepressants)	1st trimester	• Identify the teratogen and timing of exposure	• Physician Evaluation and Management • Genetic counseling • Detailed anatomy ultrasound

			• Possible fetal echo at 22-26 weeks • Serial Growth Ultrasound if Indicated

Diagnosis / Symptom	When to initiate referral:	Referring provider's initial evaluation/management and information to send with the referral	MFM visit will likely include:
Fetal Complications			
Arrhythmia	When identified	• Define when arrhythmia was noted (onset, frequency)	• Physician Evaluation and Management • Detailed anatomy ultrasound • Possible fetal ECHO at 22-26 weeks • Serial Growth Ultrasound if Indicated
Alloimmunization	If the titer is <1:16, repeat titers monthly until they rise 2-fold or reach 1:16 and FOB is antigen position then refer to MFM at 16-20 weeks	Antibody identification and titer results • Records from prior affected pregnancies • Past history including OB history, if father of the current pregnancy is the same, transfusion history	• Physician Evaluation and Management • Potential testing of the FOB for antigen status • Detailed anatomy ultrasound and evaluation of Middle cerebral artery Doppler • Serial Growth Ultrasound if Indicated
Growth disorders (fetal growth restriction FGR or macrosomia)	When identified	• OB history and prenatal records • All ultrasounds from current pregnancy • Genetic screening results (if done)	• Physician Evaluation • Detailed anatomy ultrasound • Serial growth ultrasounds
Multiple Pregnancy			
Multifetal pregnancies (including but not limited to, mono/di twins, mono/mono twins, higher-order multiples, twin to twin transfusion syndrome)	1st trimester to determine chronicity	• Records from fertility specialists (if used)	• Physician Evaluation and Management • Detailed anatomy ultrasound • Serial ultrasounds starting at 16 depending on type of multiple gestation.

			• Coordination of care if needed
Twin to twin transfusion syndrome or selective fetal growth restriction	When identified	• Prenatal records • All OB ultrasounds • Genetic screening (if done)	• Physician Evaluation and Management • Detailed anatomy ultrasound • Coordination of care • Serial Dopplers and growth ultrasound

Diagnosis / Symptom	When to initiate referral:	Referring provider's initial evaluation/management and information to send with the referral	MFM visit will likely include:
Genetic Conditions			
Personal or family history of an isolated congenital anomaly (cardiac, neural tube, orofacial clefting)	Preconception or 1st trimester	• Must be 1st or 2nd degree relative (sibling, half-sibling, parent, uncle/aunt, nephew/niece, or grandparent. • Specify the anomaly and the relationship to the family member with the anomaly	• Physician Evaluation and Management • Genetic counseling • Offer early screening ultrasound in late 1st trimester • Detailed anatomy ultrasound at 18-20 weeks
Personal of family history of a specific genetic disorder	Preconception or 1st trimester	• Specify diagnosis or genetic abnormality (translocation, microdeletion/duplication, etc) • Genetic testing results • Relationship to family member with genetic disorder	• Physician Evaluation and Management • Genetic counseling • Offer early screening ultrasound in late 1st trimester • Detailed anatomy ultrasound at 18-20 weeks
Personal of family history of a non-specific genetic disorder	Preconception or 1st trimester	• Condition for which there has been no genetic testing and no specific genetic diagnosis (ie- autism, intellectual disability)	• Physician Evaluation and Management • Genetic Counseling • Offer early screening ultrasound in late 1st trimester • Anatomy/growth ultrasound at 18-20 weeks

		• Relationship to family member with genetic disorder	

OhioHealth Maternal Fetal Medicine has developed these guidelines as a reference tool to assist referring physicians. Obstetric medical needs are complex, and these guidelines may not apply in every case. OhioHealth Maternal Fetal Medicine relies on referring providers to exercise their own professional medical judgment about the appropriate treatment and management of their patients. Referring providers are solely responsible for confirming the accuracy, timeliness, completeness, appropriateness, and helpfulness of this material in making all medical, diagnostic, or prescription decisions.