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Accredited with the American Institute of Ultrasound in Medicine
 and by the Fetal Medicine Foundation

Patient Name: _____

Referring Physician Signature: _____ **Date:** _____

REASON FOR REFERRAL (PLEASE SELECT AS MANY AS APPLICABLE)

- Advanced Maternal Age (AMA)
- IUGR
- Abnormal Screening (1st or 2nd trimester)
- Placental Problem
- Diabetes/Gestational Diabetes
- Preterm Labor
- Fetal Anomaly
- Multiple Gestations
- Incompetent Cervix
- Uterine Anomaly
- LEEP/CONE
- Medical Disorder _____
- Recurrent Pregnancy Loss
- Post Dates/Post Term
- Polyhydramnios/Oligohydramnios
- IVF/IUI
- Uncertain LMP
- Other _____

DESIRED SERVICES:

- First trimester Screening ultrasound with NIPT and free beta HCG/PAPP A
- First Trimester Screening and Nuchal Translucency
- Genetic ultrasound b/w 16-18 weeks
- Level II ultrasound
- Consultation/genetic counseling
- Biophysical Profile
- Diabetes/GDM counseling and management
- Follow up Ultrasound
- Transvaginal Ultrasound
- 3D Transvaginal ultrasound (pregnant and non-pregnant)
- Fetal Echocardiogram
- Amniocentesis (please include pertinent blood work)
- Preeclampsia screening – Uterine artery Doppler
- Fetal Doppler assessment
- Other _____
- Any Significant Medical History: _____

Please provide any additional information.

PLEASE CIRCLE REQUESTED LOCATION AND ADDRESS:

1850 Town Center Pkwy
 Suite 258
 Reston, VA 20190-3219
 (703) 435-1454
 (703) 435-8630 fax

44035 Riverside Parkway
 Suite 345
 Lansdowne, VA 20176-8273
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 Suite 210
 Gainesville, VA 20155-3260
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24430 Stone Springs Blvd
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