

**OUTSIDE ORDER FORM**

Reference the attached form(s) for pricing and scheduling considerations. Additional tests or procedures may be available upon request. Copies of forms can be accessed at <https://footprintsmidwifery.com/resources/provider-orders>

**Patient Information:**

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone Number: \_\_\_\_\_

**Ordering Provider Information:**

Provider Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

**Dx (ICD-10) or Pt. Hx:** \_\_\_\_\_

**LMP:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**EDD:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Requested Footprints Location:**     Black River Falls     Greenwood

**Requested Service Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

We will call patient at the number above to confirm appointment.

**Payment Preference:**

Self-Pay     United Healthcare     Security Health     WEA

Forward Health (Non-HMO)     Other (Please contact office first)

**Labs:**

OB Panel (CBC w/ Auto Diff, ABORH, Antibody Screen, Syphilis, Rubella, Hep B)

1hr Glucola     2hr Glucola     A1C     Antibody Screen

ABORH     CBC w/ Auto Diff     GBS     hCG Quant

Hemoglobin     Progesterone

**Ultrasound:**

Early US (Transvaginal)     Fetal Anatomy Scan (18 – 22wks)     Follow Up / Limited OB

**Other:**

Newborn Circumcision (≤14 days old)

**Provider Signature:** \_\_\_\_\_

**Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_