WOMAN RISING MIDWIFERY

Provider Referral Form

Woman Rising Midwifery
4123 University Avenue
Des Moines, IA 50311
562-505-7603
womanrisingmidwifery@gmail.com

PROVIDER REFERRAL FOR NONSTRESS TEST

Name of Patient: _____ **Date of Birth:** _____

Estimated due date? _____ **Gravida/Para** _____

Indication for Nonstress Test: _____

Relevent Medical History to this test: _____

I, _____ (OB/GYN, Family Doctor, or Midwife), request that Woman Rising Midwifery or one of their representatives perform a Nonstress test on my client, which will then be interpreted by Rebecca Schleuger-Valadao, CNM. I understand that my client will be referred to emergency services if the NST indicates the need.

_____ _____

Provider Signature **Date**

PLEASE PERFORM A NONSTRESS TEST

☐ Please perform a nonstress test according to ACOG standards for minimum monitoring period of 20 minutes. If nonreactive or equivocal, I request immediate notification from Woman Rising Midwifery, to further direct care of my patient. I have made my client aware that $125 will be due at the time of the test.

_____
Provider Initials

PLEASE DRAW THESE ADDITIONAL LABS

☐ I request lab work to be drawn. I am aware this this will incur an additional $20 fee to my client, due at time of drawing.

_____
Provider Initials

PLEASE CONTACT ME WITH RESULTS

☐ Please send the original strip with the client. I understand that Woman Rising Midwifery will keep a photocopy of this strip in their files, along with a patient facesheet for proper record keeping. Please contact me with results within 4 hours if reactive, and immediately for nonreactive tests.

_____
Provider Initials