Pregnancy Notification (First Prenatal Visit)

Please fax **This page** to 702-691-5620
(Must be faxed within 15 days of first visit)

Type of Referral:

Language Preference: ______________________

☐ Pregnancy Notification ☐ High Risk Pregnancy ☐ Miscarriage/Termination Notification

Culinary ID#: ______________________

Patient Name: ______________________

Street Address: ______________________

City/State: ______________________

Phone: ______________________

Date of Birth: ______________________

LMP: ____________ EDC: ____________ Gestational Age: ____________

PARA: ____________ GRAVIDA: ____________ Previous C-Section: ____________

Physician: ______________________

Street Address: ______________________

City/State/Zip: ______________________

Phone: ______________________

Tax ID#: ______________________

***Flow chart will be required after delivery** (fax to 702-691-5620).

The information contained in this facsimile is confidential and includes protected patient health information. The information is intended only for the use of CHF and its designees.

If you are not the intended recipient or the employee or the agent responsible to deliver it to the intended recipient, you are hereby notified that any use, disclosure, distribution or copying of this communication is strictly prohibited. If you have received this facsimile in error, please immediately notify us by telephone at 702-892-7393 and return the original message to us at CHF, 1901 Las Vegas Blvd South, Suite 101, Las Vegas, NV 89104.

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