

# WASHINGTON UNIVERSITY OBGYN

## Maternal Fetal Medicine - Ultrasound Services & Locations

**Shiloh, IL** Thursday 8 am – 4 pm (Ultrasound & MFM)

Friday 8 am – 4 pm (Ultrasound)

**Progress West** Thursday 8 am – 12 pm (Ultrasound)

**South County CAM** Wednesday 8 am – 4 pm (Ultrasound)

### Shiloh, IL

- |  |   |
|--|---|
| <ul style="list-style-type: none"> <li>• Gynecologic Ultrasound (TA and/or TV)</li> <li>• Viability/Dating &lt; 14 weeks</li> <li>• First Look (11-13.6 weeks) – Nuchal Translucency measurement</li> <li>• Standard (gestational age assignment/anatomic survey) (20 weeks) with transvaginal if &lt; 24 wks</li> <li>• cffDNA</li> </ul> | <ul style="list-style-type: none"> <li>• Specialized (anatomic, AMA; IDDM; drug exposure; presence of ultrasound markers; MC twins)</li> <li>• Growth/Repeat (re-evaluation fetal size and/or re-examination of specific organs(s))</li> <li>• Cervical length</li> <li>• Umbilical and/or fetal Doppler</li> <li>• Limited – AFV, fetal position, placental location, FHM</li> </ul> |
|--|---|

### Progress West & South County CAM

- |  |   |
|--|---|
| <ul style="list-style-type: none"> <li>• Gynecologic Ultrasounds (TA and/or TV)</li> <li>• Viability/Dating &lt; 14 weeks</li> <li>• Standard (gestational age assignment/anatomic survey) (19–20 weeks) with transvaginal if &lt; 24 wks</li> <li>• Specialized (anatomic, AMA; IDDM; drug exposure; presence of ultrasound markers; MC twins)</li> </ul> | <ul style="list-style-type: none"> <li>• Growth/Repeat (re-evaluation fetal size and/or re-examination of specific organs(s))</li> <li>• Cervical length</li> <li>• Umbilical and/or fetal Doppler</li> <li>• Limited – AFV, fetal position, placental location, FHM</li> </ul> |
|--|---|

### Center for Outpatient Health (COH7) & MoBap

- |  |  |
|--|--|
| <ul style="list-style-type: none"> <li>• Gynecologic Ultrasound (TA and/or TV)</li> <li>• Rule out Ectopic/PUL</li> <li>• Viability/Dating &lt; 14 weeks</li> <li>• First Look (11-13.6 weeks) – Nuchal Translucency measurement / Include counseling If needed</li> <li>• Standard (gestational age assignment/anatomic survey) (20 weeks) with transvaginal if &lt; 24 wks</li> <li>• Specialized (Including, but not limited to: known or suspected anatomic or genetic abnormality or increased risk for same; AMA; IDDM; drug exposure; presence of ultrasound markers; MC twins) with transvaginal if &lt; 24 wks</li> <li>• cffDNA</li> <li>• Genetic Counseling</li> </ul> | <ul style="list-style-type: none"> <li>• Growth/Repeat (re-evaluation fetal size and/or re-examination of specific organs(s) known or suspected to be abnormal)</li> <li>• Biophysical profile (NSTs performed only at Center for Outpatient Health and Missouri Baptist Medical Center)</li> <li>• Cervical length</li> <li>• Umbilical and/or fetal Doppler</li> <li>• Limited – AFV, fetal position, placental location, FHM, rule out ectopic, other:</li> <li>• SIS (Saline Infusion Sonography)</li> <li>• Amniocentesis (15–20 weeks)</li> <li>• CVS (10–13 weeks)</li> <li>• Fetal Care (COH7 ONLY)</li> </ul> |
|--|--|

**Carrie Gower**

MFM & Fetal Care  
Practice Manager  
(314) 747-8379  
Cell: (618) 719-1675  
Fax: (314) 747-1429  
[cgower@wustl.edu](mailto:cgower@wustl.edu)

**Jessica Bergmann**

Ultrasound Clinic Manager  
(314) 747-5316  
Cell: (314) 766-2520  
Fax: (314) 273-3530  
[jessica.m.bergmann@wustl.edu](mailto:jessica.m.bergmann@wustl.edu)

## **\*\*EPIC USERS\*\*** - ULTRASOUND ORDER CHEAT SHEET

\*\*\*You must type in the highlighted IMG code for the corresponding ultrasound

\*\*To request consult AND ultrasound use referral ([REF 430234](#)) AND include the US order separately

<b>LMT</b>	<b>IMG2909</b> - OB US LIMITED	<i>Check Viability, PUL, Check Placenta, Dopplers or BPP's, Complete Anatomic Survey</i>
<b>RPT</b>	<b>IMG2910</b> - US OB FOLLOW UP	<i>Check growth along with BPP and or Dopplers</i>
<b>STN</b>	<b>IMG2907</b> - US OB 14 WEEKS OR OVER	<i>Anatomic Survey that's low risk</i>
<b>SPC</b>	<b>IMG534</b> - OB US DETAIL FETAL ANATOMY SINGLE OR FIRST GESTATION	<i>Anatomic Survey high risk (AMA, BMI over 35, ART, IDDM, and family hist. of anomalies)</i>
<b>FLK</b>	<b>IMG2912</b>	<i>First Look (11-13.6 weeks GA)-Nuchal Translucency measurement</i>
<b>CVS</b>	<b>IMG562</b>	<i>Chorionic Villus Sampling (10-13.6 weeks GA)/include counseling</i>
<b>AMNIO</b>	<b>IMG2712</b>	<i>Amniocentesis (&gt;/=15 weeks GA)/include counseling</i>
<b>MISC LAB cffDNA</b>	<b>LAB000</b>	<i>Cell Free Fetal DNA</i>
<b>GYN/Pelvic</b>	<b>IMG2722</b> - US PELVIS COMPLETE	<i>Non-pregnant pelvic ultrasound</i>
<b>SIS</b>	<b>IMG2721</b> - US SONOHYSTEROGRAPHY	
<b>GC</b>	<b>AMB Referral to OB GENETIC COUNSELING</b> (do NOT use IMG9999). Process see next pg.	

On the right is an example of a  
*Standard Anatomy scan*

Select **Washington University**  
**(All Locations)** and  
then **select the site** where you  
would like the ultrasound  
scheduled.

In the **free text** below is where  
you can put any notes on  
reason for this ultrasound.

Where should this order be performed? **Washington University (All Locations)**

Please select the performing department: **WU OB US PWC**

**BIJH COH 3 ULTRASOUND** **BIJH COH 7 ULTRASOUND** **WU OB US REI 4444 FP**  
**BIJH S8LD ULTRASOUND** **MBMC 450D WU US** **WU OB US PWC** **WU OB C3 COH 7**  
**WU OB FAM COH 7** **WU OB FCC COH 7** **WU OB GYN CAM SC 1700** **WU OB GYN COH 7**  
**WU OB MFM COH 7** **WU OB MFM MBMC 450D** **WU IL OB US MT VERNON**  
**WU IL OB US MARYVILLE** **WU OB US CAMSOC 1700** **WU IL OB US MHE1 140**  
**WU IL OB US REI SHILOH**

Sched Inst: **Please arrive with a full bladder**

Process Inst: Outpatient radiology order priorities:

Schedule ASAP, Read ASAP - To be used for patients with a clinic appointment today or patient/MD awaiting results.

Schedule ASAP, Read routine - To be used for patient convenience when patient lives out of area.

Routine and future appointments

Comments: **CPT 76805**

Last Resulted: Order #186879369  
 Ordered: 8/29/18 11:44 AM  
 Resulted: 8/29/18 7:06 PM  
 Collected: 8/29/18 1:13 PM

Component	Value	Units	Flag
1. ESTIMATED FETAL WEIGHT	643	g&grams	
2. FETAL PRESENTATION	Vertex		
3. FETUS#	Fetus1		

Reason for Exam: **[Redacted]**

Reason for Exam (Free Text): **[Redacted]**

CC Results: **Recipient** **Modifier** **Add PCP**

## NEW GENETIC COUNSELING ORDER

1. In the Visit Taskbar, at the bottom of the screen Click **+Add Order**
2. Enter **AMB Referral to OB Genetic Counseling**

3. Double-click the order to select if from the list.
4. Modify order details, such as the reason for referral and any required items
5. After updating the order details, click **✓Accept**

## Add this NEW order to your Preference List

6. Before signing the order, click ☆ to add it to your preference list

7. In the Add To Preference List window, enter any other details you want to use when you place this order in the future, and click **Accept**
  - a. In the **Display name** field, enter an easy-to-remember name for the order. The next time you need to place this order, you can search for your saved order using this name.
  - b. In the **Section** field, enter the section of your preference list in which you want this order to appear. Or, click **New Section** to add another section to your list.

WASHINGTON UNIVERSITY  
MATERNAL-FETAL MEDICINE  
ULTRASOUND REFERRAL ORDER FORM  
FOR **NON-EPIC USERS**

*If no response within 48 hours, please call 314-454-8181.*

PATIENT NAME ( <i>last, first, M.I.</i> ):						Date of birth:	
Interpreter <input type="checkbox"/> Yes - If yes, language: _____ <input type="checkbox"/> No							
Patient address:							
Patient home phone:				Patient alternate phone:			
<b>*Required*</b> Insurance name (plan name):							
Name of policy holder:							
Policy ID #:		ID#:		Relationship to insured:			
Referring physician:				Office contact person:			
Office phone #:				Office fax #:			
Primary obstetrician, if not referring physician:							
Preferred scan location: <input type="checkbox"/> BJH - Center for Outpatient Health <input type="checkbox"/> Missouri Baptist Medical Center <input type="checkbox"/> Progress West Hospital <input type="checkbox"/> Shiloh, IL* <input type="checkbox"/> South County - Center for Advanced Medicine							
Indication for referral (DX):							
<b>GYNECOLOGIC ULTRASOUND</b> <input type="checkbox"/> TA and/or TV <input type="checkbox"/> SIS (Saline Infusion Sonography)							
<b>OBTETRIC ULTRASOUND</b>		LMP:		EDD:		EDD based on LMP/Ultrasound/Other:	
		BMI:		Number of fetuses:			
<input type="checkbox"/> Rule out Ectopic/PUL <input type="checkbox"/> Viability/Dating < 14 weeks							
<input type="checkbox"/> First Look (11-13.6 weeks) – Nuchal Translucency measurement / Include counseling: <input type="checkbox"/> Yes <input type="checkbox"/> No							
<input type="checkbox"/> Standard (gestational age assignment/anatomic survey) (19–20 weeks) with transvaginal if < 24 wks							
<input type="checkbox"/> Specialized (Including, but not limited to: known or suspected anatomic or genetic abnormality or increased risk for same; AMA; IDDM; drug exposure; presence of ultrasound markers; MC twins) with transvaginal if < 24 wks							
<input type="checkbox"/> Growth/Repeat (re-evaluation fetal size and/or re-examination of specific organs(s) known or suspected to be abnormal)							
<input type="checkbox"/> Biophysical profile (NSTs performed only at Center for Outpatient Health and Missouri Baptist Medical Center)							
<input type="checkbox"/> Cervical length <input type="checkbox"/> Umbilical and/or fetal doppler							
<input type="checkbox"/> Limited – AFV, fetal position, placental location, FHM, rule out ectopic, other:							
<b>DIAGNOSTIC TESTING</b> <input type="checkbox"/> Amniocentesis (15–20 weeks) <input type="checkbox"/> CVS (10–13 weeks) <input type="checkbox"/> Fetal lung maturity <i>( Authorization may be required, please verify with the insurance company. Blood type is required.)</i>							
<b>GENETIC COUNSELING</b> <input type="checkbox"/> Pre-conception counseling <input type="checkbox"/> First Look counseling <input type="checkbox"/> Counseling with diagnostic testing							
Please list indication (abnormal serum screen, personal/family history of heritable condition, cell-free fetal DNA testing, etc):  							
<b>MATERNAL-FETAL MEDICINE</b>		Indication for referral (DX):					
<input type="checkbox"/> Pre-pregnancy consult		<input type="checkbox"/> OB consult		<input type="checkbox"/> Co-management of care		<input type="checkbox"/> Transfer of care <input type="checkbox"/> Fetal care	
				Required - Physician signature:			Date: