MotherToBaby
Medications & More During Pregnancy & Breastfeeding
Ask The Experts

Toll- Free (877) 311-8972

Fax (858) 246-1710

Fax Referral Form MotherToBaby Studies conducted by OTIS

Patient's Name: _____

Patient's home number: _____Patient's cell/work number_____

Preferred language: [ ] English [ ] Spanish

Preferred contact day: [ ] Mon [ ] Tues [ ] Wed [ ] Thurs [ ] Fri [ ] Anytime

Preferred contact time: _____ [ ] a.m. [ ] p.m. [ ] Anytime

May we leave a message? [ ] Yes [ ] No

Estimated Due Date: _____ Less than 20 week of gestation: [ ] Yes [ ] No

Patient has:

[ ] Autoimmune Disease:

- [ ] Ankylosing Spondylitis
- [ ] Psoriatic Arthritis
- [ ] Psoriasis
- [ ] Giant Cell Arteritis
- [ ] Systemic Sclerosis (SSc)
- [ ] Rheumatoid Arthritis
- [ ] Crohn's Disease
- [ ] Ulcerative Colitis

[ ] Multiple Sclerosis

[ ] Physician-diagnosed Asthma or use of Asthma medications

[ ] Atopic Dermatitis / Moderate to severe Eczema

[ ] Endometriosis

[ ] Hypercholesterolemia (FH)/ ASCVD

[ ] Exposure to TDAP / Pertussis vaccine

[ ] Non-diseased controls:

Referred by : _____ Date referred: _____
Last Name/ Referral Service or Location

Patient agrees to be contacted by the Coordinating Center for OTIS Studies

[ ] Verbal consent
[ ] Written consent

Signature: _____