USF HEALTH | TAMPA GENERAL HOSPITAL FETAL CARE CENTER

ACARDIAC TWIN REFERRAL

Please fax this form, sono report and prenatals to: (813) 821-8390.

TODAY'S DATE_____ /_____ /_____ **REFERRING DIAGNOSIS** ____________________________________

Patient's Last Name ______________________________ First Name ___________________________ Age_______

Patient's Home Phone____________________ Cell _____________________Date of Birth _____ /_____ /_____

Gravida________ Para ________ Ab ______ Living Children _______ GA _______ LMP _________ EDC ___________

REFERRING PHYSICIAN____**PHONE**_______________

Address____ Fax___________________

City____ State ________________ Zip___________________

PLACENTA The placenta is located on which uterine surface: Anterior_______ Posterior_______ Fundal_______

BIOMETRY DISCORDANCE

Measurement of the abdominal circumference (including skin edema)

Acardiac _______cm

Pump twin _______cm

AMNIOTIC FLUID

The maximum vertical pocket in each sac was measured to be:

Acardiac _______cm

Pump twin _______cm

FETAL HYDROPS

Does the pump twin exhibit evidence of:

Abdominal ascites _______Yes _______No

Scalp edema _______Yes _______No

Pleural effusion _______Yes _______No

Poor contractility _______Yes _______No

FETAL ECHO _______Yes _______No Findings ____________

CERVICAL LENGTH-REQUIRED

Via transvaginal scanning, the cervical length appeared to measure _______cm Funneling? _______ Yes _______No

If cervix measures < 2.5cm a cerclage may be required prior to laser therapy.

HAS THE PATIENT HAD SERUM SCREEN TESTING? _______Yes _______No

If this test has been done is there an increased risk for:

Down's Syndrome? _______Yes _______No Neural tube defect? _______Yes _______No Other?_______

HAS THE PATIENT HAD NON-INVASIVE PRENATAL TESTING? _______Yes _______No

If this test has been done is there an increased risk for:

Down's Syndrome? _______Yes _______No Other?_______

HAS THE PATIENT HAD CVS? _______Yes _______No

If CVS has been performed, please state the fetal karyotype: _______46, XX _______46, XY Other?_______

Fetal Care Center

AMNIOCENTESIS

Has the patient undergone any amniocentesis procedures? ________Genetic ________Therapeutic ________None

If a genetic amniocentesis has been performed, please state the fetal kayotype: ________46, XX ________46, XY

Other?________

If therapeutic (decompression) amniocentesis has been performed, please complete the following:

Date	Amount Removed	Fluid Color	Placenta Penetrated	Outer Membrane Detachment	Disruption of dividing membrane (Septostomy)	Gross Rupture of Membranes (PROM)
			Yes | No	Yes | No	Yes | No	Yes | No
			Yes | No	Yes | No	Yes | No	Yes | No
			Yes | No	Yes | No	Yes | No	Yes | No

INCOMPETENT CERVIX

Does this patient have a history of an incompetent cervix? _______Yes ________No

Has a cerclage suture been performed with this pregnancy? _______Yes ________No

PRETERM LABOR

Has this patient experienced any symptoms of preterm labor? _______Yes ________No

Have any medications for preterm labor been administered? _______Yes ________No

List: ____

____

MEDICAL HISTORY

Please list any pertinent maternal medical conditions (i.e. diabetes, hypertension, lupus, CHD, etc.)

____

____

OFFICE USE ONLY:	
Date Received	Diagnosis
Recommendation	Follow Up

Thank you for your referral. We will get back with you as soon as possible.

e-mail: **fcc@tgh.org** · Phone (813) 821-9124 · Fax (813) 821-8390

USF Health | TGH Tampa General Hospital