USF HEALTH

FETAL CARE CENTER OF TAMPA BAY
ACARDIAC TWIN REFERRAL QUESTIONNAIRE

Please fax this form, sono report and prenatals including demographics to: (813)259-0839
e-mail: fcc@tgh.org PHONE: (813) 259-8513

Date _____

Patient _____ **Age** _____ **Maternal Height** _____ **Weight** _____

Physician _____ **LMP** ____ **EDD** ____ **EGA** ____ **Twins** ___ **Triplets** _____

Physician Phone No. _____ **Fax** _____

Physician Address _____

City/State _____ **Insurance Co** _____

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? _____

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 _____