USF HEALTH

FETAL CARE CENTER OF TAMPA BAY
LOWER OBSTRUCTIVE UROPATHY REFERRAL FORM

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** _____

ULTRASOUND DATE	RIGHT KIDNEY	LEFT KIDNEY
RENAL PELVIS	_____ mm	_____ mm
RENAL PARENCHYMA	_____ Normal _____ Echogenic	_____ Normal _____ Echogenic
CYSTIC DYSPLASIA	_____ No _____ Yes	_____ No _____ Yes

AMNIOTIC FLUID VOLUME **Maximum Vertical Pocket** _____ **cm** **AFI** _____ **cm**

BLADDER DIAMETER _____ **x** _____ **x** _____ **cm**

KEYHOLE SIGN _____ **No** _____ **Yes** **ASCITES** _____ **No** _____ **Yes**

1. **If a serum screen or non-invasive prenatal testing has been performed is there an increased risk for:**
Down's Syndrome? ____ **Yes** ____ **No** **Neural tube defect?** ____ **Yes** ____ **No** **Others?** ____ **Yes** ____ **No**

Details _____

2. **Has the patient undergone any diagnostic genetic procedures?** ____ **Amnio** _____ **CVS** ____ **None**

3. **If a diagnostic genetic procedure has been performed, please provide: Date** _____ **Results** _____

If you have performed a vesicocentesis, please complete.	VESICO #1 DATE _____	VESICO #2 DATE _____
Sodium (Na) < 100mEq/dl		
Chloride(Cl) < 90mEq/dl		
Osmolality(Osm) < 210mOsm/L		
Calcium(Ca++) < 8mEq/dl		
Beta2 < 10mg/l		
Protein < 20mg/dl		

Office use only:
DATE RECEIVED _____
DIAGNOSIS _____
RECOMMENDATION _____
FOLLOW UP _____