FETAL CARE CENTER OF TAMPA BAY (FCCTB) REFERRAL QUESTIONAIRE
Please fax this form, sono report, prenatals including demographics to: (813) 259-0839
e-mail: fcc@tgh.org PHONE: (813) 259-8513

Today's Date ____/____/___ **Referring Diagnosis** _____

Patient's Last Name _____ First Name _____ Age _____

Patient's Home Phone _____Cell _____ Date of Birth ____/____/___

Gravida_____Para_____ Ab_____Living Chidren_____ GA _____LMP _____EDC_____

Allergies _____Ht _____Wt_____ Insurance Company _____

Referring Physician _____ Phone _____

Address _____ Fax: _____

City _____ State _____ Zip _____

1. Have the parent(s) been told about the baby's diagnosis? _____

2. Any needs/concerns expressed by the parent(s). _____

3. If a triple/quad screen has been performed is there an increased risk for: Down's Syndrome? ___Yes____No
Neural tube defect? ____Yes ___No Others? ____Yes ___No Please list: _____

4. Has the patient undergone any diagnostic genetic procedures? ___ Amnio ___ CVS ___ None

5. If a diagnostic genetic procedure has been performed, please provide: Date_____ Results_____

6. Does this patient have a history of any cervical shortening? ____ Yes _____ No; if Yes, Cervical Length _____

7. Has this patient experienced any symptoms of preterm labor? _____ Yes _____ No

8. Please list any medications/interventions for preterm labor?
Cervical Cerclage? ____Yes ___No Steroids? _____ Progesterone Therapy? _____
List any Tocolytic Agents: _____

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

10. Please list both prescription and over the counter medications (baby aspirin) that the patient is taking?
_____

11. Anticipated site of delivery? _____

12. May we contact the patient at this time? ____Yes ___No
Name and phone number of person completing this form: _____

Thank you for this referral.
Julie Johnson, RNC, BSN, Perinatal Navigator/Fetal Care Center Coordinator