USF HEALTH

# FETAL CARE CENTER OF TAMPA BAY REFERRAL QUESTIONAIRE

## TWIN-TWIN TRANSFUSION SYNDROME (TTTS)

**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_____Maternal Height_____Welght_____

Referring Physician_____ Best contact phone #_____

Address_____ Phone_____

Fax_____

City_____ State_____ Zip_____

**TTTS** defined as a monochorionic twin pregnancy with a Maximum Vertical Pocket <2cm in the Donor and >Scm in the Recipient. The Donor may or may not have a visible bladder. Size discordance is no longer considered a criteria.

**IUGR** is defined as one fetus being less than the lath percentile while the other fetus is appropriately grown (AGA). Although amniotic fluids may be discordant, they do not meet the criteria for TITS. (<2cm and >Scm.). Our protocol for laser surgery for SIUGR requires absent or reverse flow in the umbilical artery.

PLACENTA LOCATION _____ANTERIOR _____POSTERIOR

CHORIONICITY _____MONO/DI _____MONO/MONO _____DI/DI _____UNKNOWN

AMNIOTIC FLUID (maximum vertical pocket in each sac) Recipient/AGA _____ cm
Donor/IUGR _____ cm

WEIGHT DISCORDANCE: Fetal Weight Measurements Recipient/AGA _____grams
Donor/IUGR _____grams

FETAL BLADDER
The urinary bladder in the Donor/IUGR fetus appeared to be:_____Filling _____Not Filling

FETAL ANOMOLIES _____YES _____NO COMMENTS_____

| ABNORMAL INTRACRANIAL U/S FINDINGS | | RECIPIENT | DONOR |
|---|---|---|---|
| Does either fetus have evidence of: | Intraventricular hemorrhage | _____Yes _____NO | _____Yes _____ NO |
| | Porencephalic cysts | _____Yes _____NO | _____Yes _____NO |
| | Ventriculomegaly | _____Yes _____NO | _____Yes _____NO |
| FETAL HYDROPS | | | |
| Does either fetus have evidence of: | Abdominal ascites | _____Yes _____NO | _____Yes _____ NO |
| | Scalp Edema | _____Yes _____NO | _____Yes _____NO |
| | Pleural Effusion | _____Yes _____NO | _____Yes _____NO |
| DOPPLER STUDIES | | | |
| Umbilical Artery | AEDV | _____Yes _____NO | _____Yes _____NO |
| | REDV | _____Yes _____NO | _____Yes _____NO |
| Ductus Venosus-Reverse Flow | | _____Yes _____NO | _____Yes _____NO |
| Pulsatile Umbilical Vein | | _____Yes _____NO | _____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 defects: _____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 Neural tube defects: _____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 underfone any amniocentesis procedures? _____genetic _____theraputic _____none

If a genetic amniocentesis has been performed, please state the fetal karyotype: _____46,XX _____46, XY _____other

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

| DATE | AMOUNT REMOVED | FLUID COLOR | PLACENTA PENETRATED | OUTER MEMBRANE DETACHMENT | DISRUPTION OF DIVIDING MEMBRANE | 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 (ie: diabetes, hypertension, lupus, CHD, ect..)

_____

Office use only:

DATE RECEIVED_____ DIAGNOSIS _____

RECOMMEDATION FOLLOW UP