USF HEALTH | TAMPA GENERAL HOSPITAL FETAL CARE CENTER

TWIN TWIN TRANSFUSION SYNDROME (TTTS)

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 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

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**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 _____therapeutic _____noneIf a genetic amniocentesis has been performed, please state the fetal karyotype: _____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 (ie: diabetes, hypertension, lupus, CHD, ect..)

_____

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

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