USF HEALTH | TAMPA GENERAL HOSPITAL FETAL CARE CENTER

REFERRAL

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_____

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 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

Fetal Care Center

USF Health | TGH Tampa General Hospital