

USF HEALTH FETAL CARE CENTER OF TAMPA BAY QUESTIONNAIRE ACARDIAC TWIN REFERRAL

Please fax this form, sono report and prenats to: 813-259-0839.

TODAY'S DATE ____ / ____ / ____

Patient _____ Age _____ Maternal Height _____ Weight _____

Physician _____ LMP _____ EDD _____ EGA _____ Twins _____ Triplets _____

Physician Phone No. _____ Fax _____

Physician Address _____

City/State _____ Insurance Co _____

PLACENTA The placenta is located on which uterine surface: Anterior _____ Posterior _____ Fundal _____

BIOMETRY DISCORDANCE

Measurement of the abdominal circumference (including skin edema)

Acardiac _____ cm

Pump twin _____ cm

AMNIOTIC FLUID

The maximum vertical pocket in each sac was measured to be:

Acardiac _____ cm

Pump twin _____ cm

FETAL HYDROPS

Does the pump twin exhibit evidence of:

Abdominal ascites _____ Yes _____ No

Scalp edema _____ Yes _____ No

Pleural effusion _____ Yes _____ No

Poor contractility _____ 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 defect? _____ 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 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 undergone any amniocentesis procedures? _____Genetic _____Therapeutic _____None
If a genetic amniocentesis has been performed, please state the fetal kayotype: _____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 (i.e. diabetes, hypertension, lupus, CHD, etc.)

OFFICE USE ONLY:	
Date Received	Diagnosis
Recommendation	Follow Up

Thank you for this referral. I will get back with you as soon as possible.

Sara Zientara, RNC, BSN, Perinatal Navigator/Fetal Care Center Coordinator

e-mail: szientara@tgh.org -or- aodibo@health.usf.edu . Phone 813-259-8513 . Fax 813-259-0839