

USF HEALTH FETAL CARE CENTER OF TAMPA BAY QUESTIONNAIRE REFERRAL

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

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 _____

Allergies _____ Ht _____ Wt _____

Insurance Company _____ Member Number _____

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. I will get back with you as soon as possible.

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

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