

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 undergone any amniocentesis procedures? ____genetic ____therapeutic ____none if 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 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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