USF HEALTH

FETAL CARE CENTER OF TAMPA BAY REFERRAL QUESTIONAIRE

TWIN TWIN TRANSFUSION SYNDROME (TTTS) / SELECTIVE INTRAUTERINE GROWTH RETARDATION (SIUGR)

Please fax this form, sono report and prenatals including demographics to: (813) 259-0839
e-mail: aodibo@health.usf.edu or pbornick@tgh.org · toll-free: (877) fetal77 · phone: (813) 259-8513

Date_____

Patient _____**Age**_____ **Maternal Height**_____**Weight**_____

Physician_____ **LMP** _____**EDD**_____**EGA**_____**Twins**___**Triplets**___

Physician Phone No. _____ **Fax**_____

Physician Address _____

City/State _____ **Insurance Co**_____

TTTS is defined as a monochorionic twin pregnancy with a Maximum Vertical Pocket <2cm in the Donor and >8cm in the Recipient. The Donor may or may not have a visible bladder. Size discordance is no longer considered a criteria.

SIUGR is defined as one fetus being less than the 10th percentile while the other fetus is appropriately grown (AGA). Although amniotic fluids may be discordant, they do not meet the criteria for TTTS. (<2cm and >8cm.). Our protocol for laser surgery for SIUGR requires absent or reverse flow in the umbilical artery.

PLACENTA LOCATION PRIMARILY _____ 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 ANOMALIES 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

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 karyotype : ____ 46, XX ____ 46, XY Other?_____

If a 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 _____

RECOMMEDATION _____ FOLLOW UP _____