



FETAL CARE CENTER OF TAMPA BAY
LOWER OBSTRUCTIVE UROPATHY REFERRAL FORM

Please fax this form, sono report and prenatals including demographics to: (813)259-0839

E-mail: aodibo@health.usf.edu or szientara@health.usf.edu · 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 _____

ULTRASOUND DATE	RIGHT KIDNEY	LEFT KIDNEY
RENAL PELVIS	_____ mm	_____ mm
RENAL PARENCHYMA	_____ Normal _____ Echogenic	_____ Normal _____ Echogenic
CYSTIC DYSPLASIA	_____ No _____ Yes	_____ No _____ Yes

AMNIOTIC FLUID VOLUME Maximum Vertical Pocket _____ cm AFI _____ cm

BLADDER DIAMETER _____ x _____ x _____ cm

KEYHOLE SIGN _____ No _____ Yes ASCITES _____ No _____ Yes

1. If a serum screen or non-invasive prenatal testing has been performed is there an increased risk for:
Down's Syndrome? _____ Yes _____ No Neural tube defect? _____ Yes _____ No Others? _____ Yes _____ No

Details _____

2. Has the patient undergone any diagnostic genetic procedures? _____ Amnio _____ CVS _____ None

3. If a diagnostic genetic procedure has been performed, please provide: Date _____ Results _____

If you have performed a
vesicocentesis, please complete.

	VESICO #1 DATE	VESICO #2 DATE
Sodium (Na) < 100mEq/dl	_____	_____
Chloride(Cl) < 90mEq/dl	_____	_____
Osmolality(Osm) < 210mOsm/L	_____	_____
Calcium(Ca++) < 8mEq/dl	_____	_____
Beta2 < 10mg/l	_____	_____
Protein < 20mg/dl	_____	_____

Office use only:

DATE RECEIVED _____

DIAGNOSIS _____

RECOMMENDATION _____

FOLLOW UP _____