USF HEALTH FETAL CARE CENTER OF TAMPA BAY QUESTIONNAIRE

ACARDIAC TWIN REFERRAL

Please fax this form, sono report and prenatals 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

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