

# USF HEALTH FETAL CARE CENTER OF TAMPA BAY QUESTIONNAIRE LOWER OBSTRUCTIVE UROPATHY 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 \_\_\_\_\_

Ultrasound Date	Right Kidney		Left Kidney	
Renal Pelvis	mm		mm	
Renal Parenchyma	<input type="checkbox"/> Normal	<input type="checkbox"/> Echogenic	<input type="checkbox"/> Normal	<input type="checkbox"/> Echogenic
Cystic Dysplasia	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> 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

*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

e-mail: [szientara@tgh.org](mailto:szientara@tgh.org) -or- [aodibo@health.usf.edu](mailto:aodibo@health.usf.edu) . Phone 813-259-8513 . Fax 813-259-0839