## USF HEALTH FETAL CARE CENTER OF TAMPA BAY QUESTIONNAIRE

# TWIN TWIN TRANSFUSION SYNDROME (TTTS)

**Please fax this form, sono report and prenatals to: 813-259-0839.**

**TODAY'S DATE**_____ /_____ /_____

Patient_____ Maternal Height_____ Weight_____

Referring Physician_____Phone_____

Address_____Fax_____

City_____ State _____ Zip_____

**TTTS** defined as a monochorionic twin pregnancy with a Maximum Vertical Pocket <2cm in the Donor and >5cm in the Recipient. The Donor may or may not have a visible bladder. Size discordance is no longer considered a criteria.

**IUGR** is defined as one fetus being less than the lath percentile while the other fetus is appropriately grown (AGA). Although amniotic fluids may be discordant, they do not meet the criteria for TITS. (<2cm and >5cm.). Our protocol for laser surgery for SIUGR requires absent or reverse flow in the umbilical artery.

Placenta Location _____ 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 ANOMOLIES** _____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 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 underfone any amniocentesis procedures? _____genetic _____therapeutic _____noneIf 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.*

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