TEXAS Children's Fetal Center   Fetal Intervention Referral Form

Date:______________________

Referring Physician:_____________________________ Primary Physician:_____________________________

Phone/Fax:_____________________________________ Phone/Fax:___________________________________
Email:____ Email:______________________________________
Street Address:_________________________________ Street Address:_______________________________
City/State/Zip:_________________________________ City/State/Zip:_______________________________

DEMOGRAPHIC INFORMATION:

Patient Name:______________________________ DOB:_____________ SSN:___________________________
Patient Address:____
Home Phone:_________________________ Cell:______________________ Work:______________________

INSURANCE: (Please FAX a copy of front and back of CARD)

Insurance Carrier:___________________________ Phone Number:_____________________ Employer:___________________
Group#:_______________________________ Policy#:________________________ Co-Pay:______________________________

IS REFERRAL NEEDED? Yes/No

Pregnancy Information:

G______ P______ LMP:_______ EDC:_________ (by U/S or LMP)

Genetic Amnio: Yes/NO (Date: _____________ Results:________________)
Placenta Location: Antertior Posterior Left/Right Lateral
Cervical Length:_____________ cm Funnelling YES/NO Cerclage YES/NO Date:_______________

Referring DX: TTTS IUGR TRAP ____________

TTTS MVP: Donor Sac:_______ Recipient Sac:________
Donor Bladder: Normal Small Absent Recipient Bladder: Normal Enlarged
Donor Doppler's: Normal Abnormal UA DV Recipient Doppler's: Normal Abnormal UA DV
Donor Ascites Hydrops Pleural Effusion Recipient Ascites Hydrops Pleural Effusion

Stage 1 Stage 2 Stage 3 Stage 4

Comments:____
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Please fax this form and all Prenatal records with LABS and ALL Ultrasound reports

Fax completed form to Karen Moise,RN   Fetal Intervention Coordinator (713) 798-2810