Keck Medicine of USC

LOS ANGELES FETAL SURGERY
ACARDIAC TWIN REFERRAL FORM

Los Angeles Fetal Surgery

DATE _____ **MATERNAL WEIGHT_____**

PATIENT_____ DOB_____ CELL PHONE _____

PHYSICIAN_____ EDC_____ EGA_____ Twins__ Triplets__

PHYSICIAN PHONE _____ FAX _____

PHYSICIAN ADDRESS _____

CITY/STATE _____INSURANCE _____

PLACENTA

The placenta is located on which uterine surface: _____ Anterior _____ Posterior _____ Fundal

BIOMETRY DISCORDANCE

Measurement of the abdominal circumference (including skin edema):
Acardiac: _____ cm TWIN A or B
Pump twin: _____cm TWIN A or B

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

CERVICAL LENGTH -REQUIRED

Via **transvaginal** scanning, the cervical length appeared to measure _____ cm

Funneling? ____ Yes ____ No

TRIPLE SCREEN

Is there and increased risk for:	Down's Syndrome	____ Yes	____ No
	Neural Tube Defect	____ Yes	____ No

If a Triple Screen has been performed, please list the results: _____

_____

AMNIOCENTESIS

Has the patient undergone any amniocentesis procedures? ____ Genetic ____ Therapeutic____ None

If a genetic amniocentesis has been performed, list the fetal karyotype: ____46, XX ____46, XY

If a therapeutic (decompression) amniocentesis has been performed, please complete the following information.

Date	Amount Removed	Fluid Color	Placenta Penetrated	Membrane Detachment	Membrane Disruption	Uterine Contractions
			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.):

_____

PLEASE FAX FORM TO: (626) 356-3379

Insurance authorization will be coordinated by Arlyn Llanes, RN/Kris Rallo, RN, who may be contacted by phone at (626)356-3360, or by email at Arlyn.Llanes@med.usc.edu or Kris.Rallo@med.usc.edu.

Internal office use:

DATE RECEIVED _____ DIAGNOSIS _____

RECOMMEDATION _____ FOLLOW UP _____