



DATE ____/____/____

PATIENT NAME _____
(Last) (First) (Middle)

DOB ____/____/____

PATIENT CELL PHONE (____) ____-____ EDC ____/____/____ EGA _____ WEIGHT _____

INSURANCE _____ INSURANCE ID# _____

REFERRING MFM _____ MFM CELL PHONE (____) ____-____
(First) (Last) (Title) (Optional)

OFFICE PHONE (____) ____-____ OFFICE FAX (____) ____-____

OFFICE ADDRESS _____
(Street) (Suite #) (City) (State) (Zip Code)

PRIMARY OB _____ OFFICE PHONE (____) ____-____
(First) (Last) (Title)

SUSPECTED DIAGNOSIS _____

ULTRASOUND DATE ____/____/____

PLACENTA LOCATION Anterior Posterior Fundal

MULTIPLES Singleton Twins Triplets Other: _____

CHORIONICITY Di-Di Mono-Di Mono-Mono Other: _____

AMNIOTIC FLUID VOLUME Maximum Vertical Pocket: _____ cm

OTHER FETAL ANOMALIES _____

FETAL HYDROPS Scalp / Skin Edema Yes No
Pleural Effusion Yes No
Pericardial Effusion Yes No
Ascites Yes No

DOPPLER STUDIES Umbilical Artery: AEDV Yes No
REDV Yes No
Umbilical Vein - Pulsatile Flow Yes No
Ductus Venosus - Reverse Flow Yes No

CERVICAL LENGTH Cervical length _____ cm
Has a cerclage been performed? Yes No

GENETIC SCREENING 1st Trimester Yes No Results: _____ NT Yes No Results: _____
2nd Trimester Yes No Results: _____ NIPT Yes No Results: _____

DIAGNOSTIC TESTING CVS Yes No Date ____/____/____ Results: _____
Amniocentesis Yes No Date ____/____/____ Results: _____

MEDICAL HISTORY Is the patient taking Aspirin? Yes No
Please list any pertinent maternal medical conditions _____

PLEASE FAX FORM TO: (626) 356-3379

PLEASE ATTACH:

- Patient demographic information
- Insurance information
- Prenatal records
- Recent consultation letters and ultrasounds reports

Please contact our office at (626) 356-3360 if you need help with the insurance authorization process.

Arlyn Llanes, RN and Kris Rallo, RN are available to answer questions by phone at (626) 356-3360 or by email at Arlyn.Llanes@med.usc.edu or Kristine.Rallo@med.usc.edu.