The Fetal Center at Children's Memorial Hermann Hospital - Complicated Multifetal Pregnancy Referral Form

Please fax this form along with all patient medical records, including patient demographics, Insurance, all prenatal records with labs and all Ultrasound Reports to 713.383.1464. For any questions, please do not hesitate to contact our office at 832.325.7288 or toll free at 1.888.818.4818.

Date: ________________

Referring Physician: ______________________________
Phone: ______________________________
Fax: ______________________________
Backline: ______________________________
Street Address: ______________________________
City/State/Zip: ______________________________
____

Primary Physician: ______________________________
Phone: ______________________________
Fax: ______________________________
Backline: ______________________________
Street Address: ______________________________
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 Insurance Card)

Insurance Carrier: ________________ Phone Number: ________________ Employer: ________________
Group #: ________________ Policy #: ________________ Co-Pay: ________________

IS REFERRAL NEEDED? ❑ YES / ❑ NO

Office Referral / Authorization Contact: ______________________________

PREGNANCY INFORMATION:

G ______ P ________ LMP: __________ EDC: __________ (by: ❑ U/S or ❑ LMP)

Genetic Amnio done: ❑ Yes ❑ No (Date: ____________ Results: ______________)
Amnioreduction done: ❑ Yes ❑ No (Date: ____________ Amount Removed: ____________)

Placenta Location: ❑ Anterior ❑ Posterior ❑ Left ❑ Right Lateral
Cervical Transvaginal Length: ________ cm Funneling? ❑ Yes ❑ No Cerclage? ❑ Yes ❑ No Date: ____________

Referring Dx: ❑ TTTS ❑ SIUGR ❑ TRAP ❑ Higher Order Multiples (3 or more Fetuses) Other: ______________

TTTS MVP of Donor Sac: __________
Donor Bladder: ❑ Present ❑ Absent
Donor Dopplers: ❑ Normal ❑ MCA PSV>1.5 MOM or <0.9 MOM
❑ UA AREDF ❑ DV A-wave Absent/Reverse Flow
Donor: ❑ Ascites ❑ Hydrops ❑ Pleural Effusion

MVP of Recipient Sac: __________
Recipient Bladder: ❑ Normal ❑ Enlarged
Recipient Dopplers: ❑ Normal ❑ MCA PSV>1.5 MOM or <0.9 MOM
❑ UA AREDF ❑ DV A-wave Absent/Reverse Flow
Recipient: ❑ Ascites ❑ Hydrops ❑ Pleural Effusion

❑ Stage 1 ❑ Stage 2 ❑ Stage 3 ❑ Stage 4

Comments : ____
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Thank you for the privilege of caring for your patient.

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