

**CHLA-USC IMFH FETAL THERAPY PROGRAM AT HOLLYWOOD PRESBYTERIAN
ACARDIAC TWIN REFERRAL QUESTIONNAIRE**

DATE _____ MATERNAL WEIGHT _____

PATIENT _____ AGE _____ LMP _____

PHYSICIAN _____ EDC _____ EGA _____ Twins _____ Triplets _____

PHYSICIAN PHONE NO. _____ FAX _____

PHYSICIAN ADDRESS _____

CITY/STATE _____ INSURANCE CO _____

PLACENTA

The placenta is located on which uterine surface:

_____ Anterior _____ Posterior _____ Fundal

BIOMETRY DISCORDANCE

Measurement of the abdominal circumference (including skin edema)

Acardiac: _____ cm

Pump twin: _____ cm

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? _____ Y _____ N

TRIPLE SCREEN

Is there an increased risk for: Down's Syndrome _____ Yes _____ No Neural Tube Defect _____ Yes _____ No

AMNIOCENTESIS

Has the pt undergone any amniocentesis procedures? ___ Genetic ___ Therapeutic ___ None

If a genetic amniocentesis has been performed, list the fetal karyotype : ___46, XX___ 46, XY

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

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 QUESTIONNAIRE TO: (323) 361-6099

Insurance authorization will be coordinated by Terri Matitino R.N. who may be contacted by phone at: (323) 361-6074, or by Email at: Tmaitino@chla.usc.edu

DATE RECEIVED _____	DIAGNOSIS _____
RECOMMEDATION _____	FOLLOW UP _____

