

**CHLA-USC-IMFH FETAL THERAPY PROGRAM AT HOLLYWOOD PRESBYTERIAN  
HOSPITAL  
LOWER OBSTRUCTIVE UROPATHY REFERRAL FORM**

DATE \_\_\_\_\_

PATIENT \_\_\_\_\_ AGE \_\_\_\_\_ Maternal Weight \_\_\_\_\_ Twins \_\_\_\_\_

PHYSICIAN \_\_\_\_\_ LMP \_\_\_\_\_ EDC \_\_\_\_\_ GA \_\_\_\_\_

PHYSICIAN PHONE NO. \_\_\_\_\_ FAX \_\_\_\_\_

PHYSICIAN ADDRESS \_\_\_\_\_

CITY/STATE \_\_\_\_\_ INSURANCE CO. \_\_\_\_\_

**REPEAT VESICOCENTESIS IN 48 HOURS ONLY IF THE VALUES ON THE FIRST VESICO ARE NOT IN THE RANGES LISTED.**

**IF NORMAL ON THE FIRST VESICOCENTESIS THE PATIENT CAN BE SCHEDULED FOR EVALUATION FOR THERAPY**

	VESICO # 1 DATE _____	VESICO # 2 DATE _____
Sodium (Na) < 100		
Chloride (Cl) < 90		
Osmolality (Osm) < 210		
Calcium (Ca++) < 8		
Beta2 < 10		
Protein < 20		

AMNIOTIC FLUID VOLUME Maximum Vertical Pocket \_\_\_\_\_ cm AFI \_\_\_\_\_ cm

BLADDER DIAMETER \_\_\_\_\_ x \_\_\_\_\_ x \_\_\_\_\_ cm

KEYHOLE SIGN \_\_\_\_\_ No \_\_\_ Yes ASCITES \_\_\_\_\_ No \_\_\_ Yes

ULTRASOUND DATE _____	RIGHT KIDNEY	LEFT KIDNEY
RENAL PELVIS	_____ mm	_____ mm
RENAL PARENCHYMA	_____ Normal _____ Echogenic	_____ Normal _____ Echogenic
CYSTIC DYSPLASIA	_____ No _____ Yes	_____ No _____ Yes

**PLEASE FAX REFERRAL FORM TO: (323) 361-6099**

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

DATE REC'D _____	DIAGNOSIS _____
RECOMMENDATION _____	FOLLOWUP _____