CHLA-USC IMFH FETAL THERAPY PROGRAM AT HOLLYWOOD PRESBYTERIAN HOSPITAL
FETAL CORDOCENTESIS/TRANSFUSION REFERRAL FORM

DATE ___________________

PATIENT____ AGE_____LMP ________Maternal Weight________

PHYSICIAN ____ EDC___________EGA_______G ____P_____

PHSICIAN PHONE NO. ______________________________________ FAX________________________________

PHYSICIAN ADDRESS ____

CITY/STATE ____INSURANCE_______________________________

FETAL ANEMIA or THROMBOCYTOPIA (Please circle one)

Suspected diagnosis: ____

PLACENTA

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

FETAL WEIGHT

The most recent measurement estimate the fetal weight: _________ grams, on _________ (date of exam)

AMNIOTIC FLUID

The maximum vertical pocket measured to be: _________ cm

OBSTETRICAL HISTORY

Number of previously affected pregnancies: _______

Please describe outcomes of previously affected pregnancies: ____________________________

____
____
____

TESTING DURING INDEX PREGNANCY (Please fill out all sections that are pertinent)

Ultrasound:

Fetal Anomalies: Yes____ No____ Comments ____

Fetal Hydrops: Yes _____ No _____

Please list all the Middle Cerebral Artery (MCA) peak systolic velocities:

Date ____ GA (wks) ____ MCA psv (cm/s^2) _____
Date ____ GA (wks) ____ MCA psv (cm/s^2) _____
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Date ____ GA (wks) ____ MCA psv (cm/s^2) _____

Amniocentesis:

Has the patient undergone any amniocentesis procedures? ____No ____Yes ____Number

If a genetic amniocentesis has been performed, please list the fetal karyotype: ____ 46, XX ____ 46, XY

If fetal blood typing was performed, please list the results: ________________________

Please list all ΔOD 450 results:

Date ____ GA (wks) ____ ΔOD 450 _____ Lilly Zone _____
Date ____ GA (wks) ____ ΔOD 450 _____ Lilly Zone _____
Date ____ GA (wks) ____ ΔOD 450 _____ Lilly Zone _____

Cordocentesis:

Has the patient undergone a cordocentesis procedure? ____No ____Yes ____Number

If a genetic study on the fetal blood was performed, list fetal karyotype: ____ 46, XX ____ 46, XY

If fetal blood typing was performed, please list the results: ________________________

Please list all hemoglobin and/or platelet count results:

Date ____ Hemoglobin Count ____ Platelet Count ____
Date ____ Hemoglobin Count ____ Platelet Count ____
Date ____ Hemoglobin Count ____ Platelet Count ____

MEDICAL HISTORY

Please list any pertinent maternal medical conditions (i.e. diabetes, hypertension, lupus, CHD, etc.)

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PLEASE FAX QUESTIONAIRE TO: (323) 361-6099

Insurance authorization will be coordinated by Terri MaitinoR.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 ______________________________