

**CHLA-USC IMFH FETAL THERAPY PROGRAM AT HOLLYWOOD PRESBYTERIAN HOSPITAL
THORACOAMNIOTIC SHUNT REFERRAL FORM**

Date _____

PATIENT _____ AGE _____ LMP _____ Maternal Weight _____

PHYSICIAN _____ EDC _____ EGA _____ Twins ___ Triplets ___

PHYSICIAN PHONE NO. _____ FAX _____

PHYSICIAN ADDRESS _____

CITY/STATE _____ INSURANCE CO _____

SUSPECTED DIAGNOSIS Macrocytic Congenital Cystic Adenomatoid Malformation (CCAM) _____
Pleural Effusion _____ Other (please write suspected diagnosis) _____

PLACENTA LOCATION PRIMARILY _____ Anterior _____ Posterior

AMNIOTIC FLUID VOLUME Maximum Vertical Pocket _____

FETAL ANOMALIES Yes _____ No _____ Comments _____

ABNORMAL INTRACRANIAL U/S FINDINGS

Does the fetus have evidence of: Intraventricular hemorrhage _____ Yes _____ No
Porencephalic cysts _____ Yes _____ No
Ventriculomegaly _____ Yes _____ No

FETAL HYDROPS

Does the fetus have evidence of: Abdominal ascites _____ Yes _____ No
Scalp edema _____ Yes _____ No
Pleural effusion _____ Yes _____ No

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

CERVICAL LENGTH-REQUIRED

Via transvaginal scanning, the cervical length appeared to measure _____ cm Funneling? _____ Yes _____ No

TRIPLE SCREEN

If this test has been done is there an increased risk for:
Down's Syndrome? _____ Yes _____ No Neural tube defect? _____ Yes _____ No

AMNIOCENTESIS

Has the patient undergone any amniocentesis procedures? _____ Genetic _____ None
If a genetic amniocentesis has been performed, please state the fetal karyotype: _____ 46, XX _____ 46, XY
If other laboratory tests have been ordered (such as TORCH titers) please fax results with this form

PLEASE FAX QUESTIONNAIRE TO: (323) 361-6099

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