

**CHLA-USC IMFH FETAL THERAPY PROGRAM AT HOLLYWOOD PRESBYTERIAN HOSPITAL
TWIN-TWIN TRANSFUSION SYNDROME (TTTS) / SELECTIVE INTRAUTERINE GROWTH
RESTRICTION (SIUGR) REFERRAL QUESTIONNAIRE**

Date _____

PATIENT _____ AGE _____ LMP _____ Maternal Weight _____

PHYSICIAN _____ EDC _____ EGA _____ Twins _____ Triplets _____

PHYSICIAN PHONE NO. _____ FAX _____

PHYSICIAN ADDRESS _____

CITY/STATE _____ INSURANCE CO _____

TTTS is defined as a monochorionic twin pregnancy with a Maximum Vertical Pocket <2cm in the Donor and >8cm in the Recipient. The Donor may or may not have a visible bladder. Size discordance is no longer considered a criteria.

SIUGR is defined as one fetus being less than the 10th percentile while the other fetus is appropriately grown (AGA). Although amniotic fluids may be discordant, they do not meet the criteria for TTTS. (<2cm and >8cm.). Our protocol for laser surgery for SIUGR requires absent or reverse flow in the umbilical artery.

PLACENTA LOCATION PRIMARILY _____ Anterior _____ Posterior

CHORIONICITY _____ Mono/Di _____ Mono/Mono _____ Di/Di _____ Unknown

AMNIOTIC FLUID Maximum Vertical Pocket in each sac
Recipient _____ cm
Donor _____ cm

WEIGHT DISCORDANCE Fetal Weight Measurements
Recipient _____ grams
Donor _____ grams

FETAL BLADDER
The urinary bladder in the Donor fetus appeared to be: _____ Filling _____ Not Filling

FETAL ANOMALIES Yes _____ No _____ Comments _____

ABNORMAL INTRACRANIAL U/S FINDINGS

	RECIPIENT		DONOR	
Does either fetus have evidence of: Intraventricular hemorrhage	_____ Yes	_____ No	_____ Yes	_____ No
Porencephalic cysts	_____ Yes	_____ No	_____ Yes	_____ No
Ventriculomegaly	_____ Yes	_____ No	_____ Yes	_____ No

FETAL HYDROPS

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

DOPPLER STUDIES –Umbilical artery : AEDV _____ Yes _____ No
REDV _____ Yes _____ No

Ductus Venosus- Reverse Flow	_____ Yes	_____ No	_____ Yes	_____ No
Pulsatile Umbilical Vein	_____ Yes	_____ No	_____ Yes	_____ No

CERVICAL LENGTH-REQUIRED

Via transvaginal scanning, the cervical length appeared to measure _____ cm Funneling ? _____ Yes _____ No
If cervix measures < 2.5cm a cerclage is required prior to laser therapy.

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 – PLEASE DO NOT PERFORM IF NOT PREVIOUSLY DONE

Has the patient undergone any amniocentesis procedures? ___ Genetic ___ Therapeutic ___ None
If a genetic amniocentesis has been performed, please state the fetal karyotype : ___ 46, XX ___ 46, XY

If a therapeutic (decompression) amniocentesis has been performed, please complete the following information :

Date of Proc	Amount Removed	Fluid Color	Placenta Penetrated	Outer Membrane Detachment	Disruption of dividing membrane (Septostomy)	Gross Rupture of Membranes (PROM)	Chorio-Amnionitis	Placental Abruption
			Yes	Yes	Yes	Yes	Yes	Yes
			No	No	No	No	No	No
			Yes	Yes	Yes	Yes	Yes	Yes
			No	No	No	No	No	No
			Yes	Yes	Yes	Yes	Yes	Yes
			No	No	No	No	No	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 Maitino R.N., who may be contacted by phone at: 323-361-6074, or by Email at: tmaitino@chla.usc.edu

DATE RECEIVED _____	DIAGNOSIS _____
RECOMMENDATION _____	FOLLOW UP _____

