



DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

PATIENT NAME \_\_\_\_\_  
(Last) (First) (Middle)

DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

PATIENT CELL PHONE (\_\_\_\_) \_\_\_\_-\_\_\_\_ EDC \_\_\_\_/\_\_\_\_/\_\_\_\_ EGA \_\_\_\_\_ WEIGHT \_\_\_\_\_

INSURANCE \_\_\_\_\_ INSURANCE ID# \_\_\_\_\_

REFERRING MFM \_\_\_\_\_ MFM CELL PHONE (\_\_\_\_) \_\_\_\_-\_\_\_\_  
(First) (Last) (Title) (Optional)

OFFICE PHONE (\_\_\_\_) \_\_\_\_-\_\_\_\_ OFFICE FAX (\_\_\_\_) \_\_\_\_-\_\_\_\_

OFFICE ADDRESS \_\_\_\_\_  
(Street) (Suite #) (City) (State) (Zip Code)

PRIMARY OB \_\_\_\_\_ OFFICE PHONE (\_\_\_\_) \_\_\_\_-\_\_\_\_  
(First) (Last) (Title)

SUSPECTED DIAGNOSIS Location: (Circle One) Left Right Bilateral

- Congenital Pulmonary Airway Malformation (CPAM) Type: (Circle One) I II III  
 Bronchopulmonary Sequestration (BPS)  Pleural Effusion  Other: \_\_\_\_\_

BETAMETHASONE  Yes  No Date #1 \_\_\_\_/\_\_\_\_/\_\_\_\_ Date #2 \_\_\_\_/\_\_\_\_/\_\_\_\_

ULTRASOUND DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

PLACENTA LOCATION  Anterior  Posterior  Fundal

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

OTHER FETAL ANOMALIES \_\_\_\_\_

FETAL HYDROPS Scalp / Skin Edema  Yes  No  
 Pleural Effusion  Yes  No  
 Pericardial Effusion  Yes  No  
 Ascites  Yes  No

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

CERVICAL LENGTH Cervical length \_\_\_\_\_ cm  
 Has a cerclage been performed?  Yes  No

GENETIC SCREENING 1<sup>st</sup> Trimester  Yes  No Results: \_\_\_\_\_ NT  Yes  No Results: \_\_\_\_\_  
 2<sup>nd</sup> Trimester  Yes  No Results: \_\_\_\_\_ NIPT  Yes  No Results: \_\_\_\_\_

DIAGNOSTIC TESTING CVS  Yes  No Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Results: \_\_\_\_\_  
 Amniocentesis  Yes  No Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Results: \_\_\_\_\_

MEDICAL HISTORY Is the patient taking Aspirin?  Yes  No  
 Please list any pertinent maternal medical conditions \_\_\_\_\_

PLEASE FAX FORM TO: (626) 356-3379

PLEASE ATTACH: 

- Patient demographic information
- Prenatal records
- Insurance information
- Recent consultation letters and ultrasounds reports

Please contact our office at (626) 356-3360 if you need help with the insurance authorization process.

Arlyn Llanes, RN and Kris Rallo, RN are available to answer questions by phone at (626) 356-3360 or by email at [Arlyn.Llanes@med.usc.edu](mailto:Arlyn.Llanes@med.usc.edu) or [Kristine.Rallo@med.usc.edu](mailto:Kristine.Rallo@med.usc.edu).