Keck Medicine of USC

LOS ANGELES FETAL SURGERY

FETAL CORDOCENTESIS/TRANSFUSION REFERRAL FORM

Los Angeles Fetal Surgery

DATE _____ **MATERNAL WEIGHT** _____

PATIENT _____ **DOB** _____ **CELL PHONE** _____

PHYSICIAN _____ **EDC**_____ **EGA**_____ **Twins**___ **Triplets**____

PHYSICIAN PHONE _____ **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:_____ g 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/s2) _____
Date _____ GA (wks) _____ MCA psv (cm/s2) _____
Date _____ GA (wks) _____ MCA psv (cm/s2) _____
Date _____ GA (wks) _____ MCA psv (cm/s2) _____
Date _____ GA (wks) _____ MCA psv (cm/s2) _____
Date _____ GA (wks) _____ MCA psv (cm/s2) _____

AMNIOCENTESIS: Has the patient undergone any amniocentesis procedures? ____Yes ____No ____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? ____Yes ____No ____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.)

_____

_____

_____

PLEASE FAX FORM TO (626) 356-3379: Insurance authorization will be coordinated by Arlyn Llanes, RN/Kris Rallo, RN, who may be contacted by phone at (626) 356-3360, or by email at Arlyn.Llanes@med.usc.edu or Kris.Rallo@med.usc.edu.

Internal office use:
DATE RECEIVED _____ DIAGNOSIS _____

RECOMMEDATION _____ FOLLOW UP _____