Keck Medicine of USC

LOS ANGELES FETAL SURGERY

LOWER OBSTRUCTIVE UROPATHY 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** _____

REPEAT VESICOCENTESIS IN 48 HOURS ONLY IF THE VALUES ON THE FIRST VESICO ARE NOT IN THE RANGES LISTED.

IF NORMAL ON THE FIRST VESICOCENTESIS THE PATIENT CAN BE SCHEDULED FOR EVALUATION FOR FETAL THERAPY.

		VESICO # 1 Date:_____	VESICO # 2 Date:_____	VESICO # 3 Date:_____
Sodium (Na)	**< 100**			
Chloride (Cl)	**< 90**			
Osmolality (Osm)	**< 210**			
Calcium (Ca++)	**< 8**			
Beta2	**< 10**			
Protein	**< 20**			
Chromosomes	☐ **Amniotic Fluid** ☐ **Fetal Urine**			

AMNIOTIC FLUID VOLUME **Maximum Vertical Pocket** _____ **cm** **AFI** _____ **cm**

BLADDER DIAMETER _____ **x** _____ **x** _____ **cm**

KEYHOLE SIGN _____ **No** _____ **Yes**

ASCITES _____ **No** _____ **Yes**

ULTRASOUND DATE: _____	**RIGHT KIDNEY**	**LEFT KIDNEY**
RENAL PELVIS	_____ **mm**	_____ **mm**
RENAL PARENCHYMA	_____ **Normal** _____ **Echogenic**	_____ **Normal** _____ **Echogenic**
CYSTIC DYSPLASIA	_____ **No** _____ **Yes**	_____ **No** _____ **Yes**

PLEASE FAX REFERRAL 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 _____

RECOMMENDATION _____ FOLLOW UP _____