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The Fetal Institute
Miami

CONGENITAL DIAPHRAGMATIC HERNIA/CPAM/BPS REFERRAL FORM

DATE: ______ / ______ / ______

REFERRING DIAGNOSIS: ____

PATIENT NAME: __________________________, ___________________________
Last First

Address: ____
City ________________________ State ________ Zip __________________
Country ____

DOB (mm/dd/yyyy): _____ /______/_____
SSN: ______ - ______ - ____________
Home Phone: ______ - ______- ________
Mobile: ______ - ______-____________
E-mail: ______________________________
Fax: ______ - ______-____________
Country of Birth ______________________

Mother's Maiden Name: ______________________ Race W/B/H/A/Other_________
Religion ____________________________________ Marital Status ____________
Emergency Contact/Next of Kin ____
Relationship __________________________
Home phone: ______ - ______-__________ Mobile: ______ - ______-________

EMPLOYER: ____
Address: ____
Phone: ______ - ______-______________

INSURANCE :
Insurance ☐ yes ☐ no (self-pay)
Insurance Provider: ____
Policy number: ________________________
Group number: ________________________
Insurance Phone: ______ - ______-_________

If other than self:
Primary subscriber name: ________________________________
DOB: _____/_____/__________
SSN: ______ - ______-__________

PHYSICIAN:
Referring Perinatologist: __________________________,_______________________
Last First

Office phone: ______ - ______ - _________

ADDRESS: ____
CITY _________________________________ STATE ________ ZIP _______________
COUNTRY ____

Fax: ______ - ______- ___________
E-mail: _______________________________

Referring Ob/Gyn : ___________________________ , ___________________________
Last First

Office Phone: ______ - ______-_______

ADDRESS: ____
CITY _________________________________ STATE ________ ZIP ________________
COUNTRY ____

Fax: ______ - ______-____________
E-mail: _______________________________

MEDICAL INFORMATION

AGE ____ G ____ P ____ LMP_____ /_____ /_____ EDC_____/_____/_____ GA: Weeks____ Days ____

Maternal Weight (lbs/Kg): ______ Maternal Height (inches/cm):____________

☐ Singleton ☐ Twins ☐ Triplets Chorionicity: ☐ D/D ☐ M/D ☐ M/M ☐ T/T ☐ D/T ☐ M/T

PLACENTA

Placental location:

☐ Anterior ☐ Posterior ☐ Fundal

AMNIOTIC FLUID

Maximum vertical pocket: _______ cm

AFI _____cm

CERVICAL LENGTH

Cervical length via transvaginal ultrasound : __________ cm

Funneling: ☐ Yes ☐ No

Cerclage ☐ In prior pregnancy ☐ In current pregnancy

GENETIC SCREENING/TESTING

☐ NIPT _____________________

☐ CVS ☐ Amniocentesis

Karyotype ☐46, XX ☐46, XY ☐Unknown

Site of lesion	☐ Right ☐ Left ☐ Bilateral
Liver in the chest	☐ Yes ☐ No
Mediastinal shift	☐ Yes ☐ No
Hydrops	☐ Yes ☐ No
Systemic feeding vessel seen	☐ Yes ☐ No

Ultrasound measurements	**Value**		
Head circumference (mm)			
Contralateral lung area traced (mm^2)			
Contralateral lung diameters (mm x mm)			
CCAM/CPAM dimensions (mm x mm x mm)			

Ultrasound index	**Value**
QLI (R) = $100 * \frac{Lung\ area\ (traced)}{(Head\ circumference)^2}$	
QLI (L) = $144 * \frac{Lung\ area\ (traced)}{(Head\ circumference)^2}$	
LHR = $\frac{lung\ area\ (diameter1*diameter2)}{Head\ Circumference}$	

MEDICAL HISTORY

Please list any pertinent medical conditions, including bleeding disorders.

____

____

CURRENT MEDICATIONS:

____

PLEASE PRINT/SCAN AND FAX/EMAIL CURRENT FORM AND DOCUMENTS TO:

FAX: +1-786-780-2060

Email: info@the-fetal-institute.com

☐ Prenatal Records ☐ Prenatal labs ☐ Progress Notes ☐ Ultrasound Reports ☐ Recent Labs ☐ Copy of Insurance Card

FOR OFFICE USE ONLY

DATE RECEIVED _______________________________ DIAGNOSIS __________________________________