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# FETAL THERAPY REFERRAL FORM

**DATE:** _____ / _____ / _____

**REFERRING DIAGNOSIS**: _____

**PATIENT NAME**: _____, _____ DOB (mm/dd/yyyy): _____ /_____/_____
Last First
SSN: _____ - _____ - _____
Address: _____ Home Phone: _____ - _____- _____
City _____ State _____ Zip _____ Mobile: _____ - _____-_____
Country _____ E-mail: _____
Fax: _____ - _____-_____
Mother's Maiden Name: _____ Race W/B/H/A/Other_____ Country of Birth _____
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 INFORMATION**
**Referring Perinatologist:** _____,_____ Office phone: _____ - _____ - _____
Last First
ADDRESS: _____ Fax: _____ - _____- _____
CITY _____ STATE _____ ZIP _____ E-mail: _____
COUNTRY _____

**Referring Ob/Gyn :** _____ , _____ Office Phone: _____ - _____-_____
Last First
ADDRESS: _____ Fax: _____ - _____-_____
CITY _____ STATE _____ ZIP _____ E-mail: _____
COUNTRY _____

**MEDICAL INFORMATION**

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

Maternal Weight (lbs): _____ Maternal Height (inches): _____

☐ Singleton ☐ Twins ☐ Triplets

Chorionicity: ☐ D/D ☐ M/D ☐ M/M ☐ T/T ☐ D/T ☐ M/T

**PLACENTA**

Placental location:

☐ Anterior ☐ Posterior ☐ Fundal ☐ Lateral R/L

**AMNIOTIC FLUID**

Maximum vertical pocket: _____ cm (A)

Maximum vertical pocket: _____ cm (B)

Maximum vertical pocket: _____ cm (C)

**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

Therapeutic amniocentesis: ☐Yes ☐No

**MEDICAL HISTORY**

☐ Diabetes ☐ Pre-gestational ☐ Gestational ☐ Diet controlled ☐ Oral hypoglycemic agents ☐ Insulin _____

☐ Chronic HTN _____

☐ Cardiac _____

☐ Renal _____

☐ Pulmonary _____

☐ GI _____

☐ Psychiatric _____

☐ Autoimmune _____

☐ Hematologic _____

☐ Other _____

_____

**CURRENT MEDICATIONS:**

_____

_____

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## 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

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FOR OFFICE USE ONLY

DATE RECEIVED _____ DIAGNOSIS _____

Rev 2018/01/20