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FETAL LOWER OBSTRUCTIVE UROPATHY
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:
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/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

Bladder Diameter _____ X _____ X _____ cm Keyhole Sign: ☐Yes ☐No Urinary ascites:☐Yes ☐No

ULTRASOUND DATE (DD/MM/YY) / /	RIGHT KIDNEY	LEFT KIDNEY
RENAL PELVIS (AP diameter)	_____ mm	_____ mm
RENAL PARENCHYMA	☐Normal ☐Hyperechogenic	☐Normal ☐Hyperechogenic
CYSTIC DYSPLASIA	☐Yes ☐No	☐Yes ☐No

If prior fetal vesicocenteses, kindly fill out the table below:

	Tap #1 DATE (MM/DD/YY) / /	Tap # 2 DATE (MM/DD/YY) / /	Tap # 3 DATE (MM/DD/YY) / /
Sodium (Na) <100mg/dL			
Chloride (Cl) < 90mg/dL			
Osmolality (Osm) <210mOsn/L			
Calcium (Ca) < 8mg/dL			
Beta2 <10mg/dL			
Protein < 20 mg/dL			

Repeat vesicocentesis in 48 hours only if the values on the first tap are not in ranges listed. If the values are below threshold on the first tap, a repeat vesicocentesis is not needed.

PRIOR SHUNT: ☐ Yes ☐ No Dates: ____/____/____; ____/____/____

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 _____