The Fetal Institute
Miami

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OPEN SPINA BIFIDA REFERRAL FORM

DATE: ______ / ______ / ______

REFERRING DIAGNOSIS: ____

PATIENT NAME: ________________________, ________________________
Last First

Address: ____
City ________________________ State ________ Zip __________________
Country ____

Mother's Maiden Name: ____________________ Race W/B/H/A/Other_________
Religion ________________________________ Marital Status ____________
Emergency Contact/Next of Kin _____________________________________
Relationship _________________________
Home phone: ______ - ______-__________ Mobile: ______ - ______-________

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

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: ______________________________

Rev 2020/04/2

MEDICAL INFORMATION

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

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

ULTRASOUND DATE (M/D/Y): ____/____/____

UPPER LEVEL OF LESION __________

CHIARI MALFORMATION / HINDBRAIN HERNIATION ("Banana sign"): ☐ Yes ☐ No

VENTRICULOMEGALY: ☐ Yes ☐ No Lateral ventricle measurement: _________ mm

FETAL KYPHOSIS: ☐ Yes ☐ No

PLACENTA LOCATION: ☐ Anterior ☐ Posterior ☐ Fundal

MULTIPLES: ☐ Singleton ☐ Twins ☐ Triplets Other: _________________

AMNIOTIC FLUID VOLUME: Maximum Vertical Pocket: _________ cm

PLACENTA PREVIA ☐ Yes ☐ No

PLACENTAL ABRUPTION / VAGINAL BLEEDING ☐ Yes ☐ No

CERVICAL LENGTH Cervical length ________ cm

History of incompetent cervix? ☐ Yes ☐ No

Has a cerclage been placed? ☐ Yes ☐ No

FETAL ECHOCARDIOGRAM DONE: ☐ Yes: ☐ Normal ☐ Abnormal Comments: ______________________________

☐ No

OTHER FETAL ANOMALIES ____

GENETIC SCREENING 1stTrimester ☐ Yes ☐ No Results: _________ NT ☐ Yes ☐ No Results: _________

2ndTrimester ☐Yes ☐ No Results: _________ NIPT ☐ Yes ☐ No Results: _________

DIAGNOSTIC TESTING CVS Yes No Date ____/____/____ Results: ___________________

Amniocentesis Yes No Date ____/____/____ Results: ___________________

MEDICAL HISTORY

Is the patient taking Aspirin? ☐ Yes ☐ No

History of singleton pregnancy delivered <37 week ☐ Yes ☐ No

Insulin-Dependent Diabetes ☐ Yes ☐ No

Maternal Rh-isoimmunization ☐ Yes ☐ No

Maternal HIV, hepatitis B or hepatitis C positive ☐ Yes ☐ No

Müllerian anomaly or uterine fibroids > 6 cm ☐ Yes ☐ No

Hypertension (chronic or pregnancy-induced) ☐ Yes ☐ No

Please list any other pertinent maternal medical conditions ____

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 ________________________________