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TWIN-TWIN TRANSFUSION SYNDROME (TTTS)
SELECTIVE INTRAUTERINE GROWTH RESTRICTION (SIUGR)
TWIN-ANEMIA-POLYCYTHEMIA SEQUENCE (TAPS)
TWIN-REVERSAL-ARTERIAL-PERFUSION SYNDROME (TRAP)
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: _____ - _____-_____

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: _____ - _____-_____

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

Working definitions:
TTTS: Monochorionic pregnancy with a Maximum Vertical Pocket ≤2cm in the Donor and ≥8cm in the in Recipient. Size discordance is not a criterion.
SIUGR: The estimated fetal weight of one of the twin in less than the 10th percentile, while the other fetus is appropriately grown (AGA). Amniotic fluid volumes may be discordant, but may not meet criteria for TTTS.
TAPS: Middle cerebral artery peak systolic velocity (MCA-PSV) ≥1.5 multiples of the median (MOM) in one twin and ≤1.0 MOM in the other twin

PHYSICIAN:
Referring Perinatologist: _____,_____
Last First

ADDRESS: _____
CITY _____ STATE _____ ZIP _____
COUNTRY _____

Office phone: _____ - _____ - _____
Fax: _____ - _____- _____
E-mail: _____

Referring Ob/Gyn : _____ , _____
Last First

ADDRESS: _____
CITY _____ STATE _____ ZIP _____
COUNTRY _____

Office Phone: _____ - _____-_____
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

	FETUS 1	FETUS 2	FETUS 3
Label (A/B/C)	A B C	A B C	A B C
D = donor, R = recipient, S = singleton An = anemic, Pc = Polycythemic , T = Trap, Pmp = Pp	D R S An Pc T Pp	D R S An Pc T Pp	D R S An Pc T Pp
Fetal Growth (AGA/IUGR)	AGA IUGR	AGA IUGR	AGA IUGR
Monochorionic	Yes No	Yes No	Yes No
Maximum vertical pocket (cm)			
Estimated fetal weight (g)			
Estimated fetal weight percentile			
Bladder visible	Yes No	Yes No	Yes No
Ascites	Yes No	Yes No	Yes No
Scalp edema	Yes No	Yes No	Yes No
Pleural effusion	Yes No	Yes No	Yes No
Pericardial effusion	Yes No	Yes No	Yes No
Intraventricular hemorrhage	Yes No	Yes No	Yes No
Porencephalic cyst	Yes No	Yes No	Yes No
Ventriculomegaly	Yes No	Yes No	Yes No
MCA-PSV MOM			
Umbilical artery AEDV/REDV	Yes No	Yes No	Yes No
Umbilical vein pulsatile flow	Yes No	Yes No	Yes No
Ductus venosus absent/reverse flow	Yes No	Yes No	Yes No

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 _____