Children's Healthcare of Atlanta
Cardiology

Fetal Cardiac Program
404-256-2593 (ext. 8012)
800-542-2233 (ext. 8012)
Fax: 770-488-9404

REQUEST FOR FETAL CARDIAC IMAGING AND CONSULTATION

PLEASE COMPLETE REQUIRED INFORMATION BELOW:

Date:______________ Mother's Name:______________________________ Mother's Date of Birth: ____________________

Phone #:_______________________________________ Cell/Work #: _______________________________________

Insurance/Medicaid Plan:___________________________ Policy & Group #: ______________________________________

Additional Contact:______________________ Relationship:____________________ Phone Number:___________________

□ If available & **legible**, please also fax copy of insurance card

OBSTETRICAL HISTORY:

Mother's EDD:________________ Maternal obesity (BMI >40)? Y / N Multiple gestation? Y / N

If multiple, # of fetuses _______

*****Is this an early gestation (14-16 weeks EGA) fetal echocardiography request? Y / N**

INDICATION FOR REFERRAL (SPECIFY BELOW):

SCREENING STUDY

All screening studies will be scheduled within 4 weeks unless otherwise specified

Specify:
- □ Maternal diabetes
- □ FHx of CHD
- □ Single UA
- □ IVF pregnancy
- □ Chromosomal abnormality
- □ Echogenic intracardiac focus
- □ Extracardiac fetal anomaly (specify): ____________________________

□ **Other (specify):** ________________________

SUSPECTED STRUCTURAL/ CONGENITAL HEART DEFECT

Please indicate timing for evaluation below

Specify:
- □ Single ventricle
- □ Hypoplastic left heart
- □ RV/LV size discrepancy
- □ Transposition of the great arteries
- □ Tetralogy of Fallot
- □ Double-outlet RV
- □ AV canal defect
- □ Ventricular septal defect
- □ Atrial septal defect

Other (specify): ____________________ ______________________________

SUSPECTED FETAL CARDIAC ARRHYTHMIA OR-CARDIAC FAILURE/DYSFUNCTION

All indications below require a STAT visit unless otherwise specified

Specify:
- □ Fetal tachycardia
- □ Fetal bradycardia/heart block
- □ Other arrhythmia
- □ Cardiomegaly
- □ Ventricular dysfunction
- □ Hydrops
- □ TTTS
- □ Fetal anemia

Other (specify): __________________

REQUEST TIMING OF EVALUATION:

□ Routine visit (within 4 weeks)	□ Urgent visit (within 1-2 weeks)	□ STAT visit (within 1-2 days)

PLEASE INCLUDE THE FOLLOWING DOCUMENTS BELOW:

□ Demographic Information □ Insurance Information □ Last Ultrasound Report □ Last Clinical Notes

****ANY RECORDS THAT INCLUDE MATERNAL MEDICAL HISTORY, SOCIAL HISTORY, PAST MEDICAL HISTORY****

REFERRING PHYSICIAN: *(Ordering Physician Signature (REQUIRED)*

Print MD Name:____________________________ Signature:_____________________________ Date:__________________

Address:____

Phone:__________________________ Fax:__________________________ E-mail: ______________________________

Referring MD specialty (please specify):

□ MFM/Perinatologist □ Obstetrician □ Cardiologist

FOR SHCC STAFF ONLY

Date and Time of Appointment: ____

Location:____ MD:____________________________________