



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 CHILDREN'S CARDIOLOGY STAFF ONLY

Date and Time of Appointment: _____

Location: _____ MD: _____