University of Miami/Jackson Memorial Hospital
Fetal Therapy Center

Thoracoamniotic Shunt Referral Form

UNIVERSITY OF MIAMI MILLER SCHOOL of MEDICINE

Jackson MEMORIAL HOSPITAL — PUBLIC HEALTH TRUST

WORKING IN ASSOCIATION

PATIENT INFORMATION

Name _____ (Last) , _____ (First)

Address _____

City _____ **State** _____ **ZIP** _____

E-mail _____

Employer _____ **Work Phone** ___ - ___ - ____

Employer Address _____

Mother's Maiden Name _____ **Race** _____

Religion _____ **Marital Status** _____

Emergency Contact/Next of Kin _____

Phone ___ - ___ - ____ **Cell** ___ - ___ - ____

DOB (MM/DD/YY) ___ / ___ / ___

SSN ___ - ___ - ____

Phone ___ - ___ - ____

Cell ___ - ___ - ____

Fax ___ - ___ - ____

Country of Birth _____

Relationship _____

INSURANCE INFORMATION

Patients relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

If other than self: **Primary subscriber name?** _____

DOB (MM/DD/YY) ___ / ___ / ___

SSN ___ - ___ - ____

Insurance Povider _____

Policy # _____

Group # _____

Insurance Phone ___ - ___ - ____

PHYSICIAN INFORMATION

Referring Perinatologist _____ (Last) , _____ (First)

Physician Address _____

City _____ **State** _____ **ZIP** _____

E-mail _____

Phone ___ - ___ - ____

Fax ___ - ___ - ____

Referring Ob/Gyn _____ (Last) , _____ (First)

Physician Address _____

City _____ **State** _____ **ZIP** _____

E-mail _____

Phone ___ - ___ - ____

Fax ___ - ___ - ____

PLEASE READ BEFORE SUBMISSION:
If using Adobe Acrobat Pro, submit by email. If using Adobe Reader, please print the form and fax.

PLEASE SUBMIT BY EMAIL OR PRINT FORM AND FAX TO (305) 357-5675

Date (MM/DD/YY) ___ / ___ / ___

FOR UM/JMH FTC USE ONLY:

Date Received (MM/DD/YY) ___ / ___ / ___

Recommendation _____

Diagnosis _____

Follow Up _____

MEDICAL INFORMATION

UNIVERSITY OF MIAMI MILLER SCHOOL of MEDICINE

Jackson MEMORIAL HOSPITAL — PUBLIC HEALTH TRUST

_____ WORKING IN ASSOCIATION _____

DATE (MM/DD/YY) ____ / ____ / ____

AGE ____ **GRAV** ____ **PARITY** ____ **LMP** ____ / ____ / ____ **EDC** ____ / ____ / ____ **GA: weeks** ____ **days** ____

☐ **Singelton** ☐ **Twins** ☐ **Triplets** **Maternal Weight** _____ lbs

Placenta

Placental location:

☐ **Anterior** ☐ **Posterior** ☐ **Fundal**

Cervical Length

Cervical length via transvaginal ultrasound: _____ cm

Funneling? ☐ **Yes** ☐ **No**

Amniotic Fluid

Maximum vertical pocket _____ cm

Amniocentesis

Genetic ☐ **Yes** ☐ **No**

If yes, karyotype ☐ **46, XX** ☐ **46, XX** ☐ **Unk**

Therapeutic ☐ **Yes** ☐ **No**

Suspected Diagnosis

Macrocystic Congenital Cystic Adenomatoid Malformation (CCAM) ☐ **Yes** ☐ **No**

Pleural Effusion ☐ **None** ☐ **Right** ☐ **Left** ☐ **Unk**

Other suspected diagnosis _____

Fetal Endocardiogram? ☐ **Yes** ☐ **No**

Triple Screen

Is there an increased risk for:

Down Syndrome?		**Neural Tube Defect?**	
☐ **Yes**	☐ **No**	☐ **Yes**	☐ **No**

Other Fetal Anomalies

☐ **Yes** ☐ **No**

Comments _____

Doppler Studies

Umbilical artery:	**AEDV**	☐ **Yes**	☐ **No**
	REDV	☐ **Yes**	☐ **No**
Ductus Venosus- Reverse Flow		☐ **Yes**	☐ **No**
Umbilical vein pulsatile		☐ **Yes**	☐ **No**

Fetal Hydrops

Abdominal ascites	☐ **Yes**	☐ **No**
Scalp edema	☐ **Yes**	☐ **No**
Pleural effusion	☐ **Yes**	☐ **No**
Pericardial effusion	☐ **Yes**	☐ **No**

Other

Intraventricular hemorrhage	☐ **Yes**	☐ **No**
Porencephalic cysts	☐ **Yes**	☐ **No**
Ventriculomegaly	☐ **Yes**	☐ **No**

Medical History

Please list any pertinent medical conditions

_____

Medications

_____

How did you hear about us?

☐ **Referral**

Name? _____

☐ **Website**

☐ **Insurance provider list**

☐ **Media**

☐ **Brochure/flyer/mailing**

☐ **Other**