University of Miami/Jackson Memorial Hospital
Fetal Therapy Center

Twin Twin Transfusion Syndrome (TTTS) / Selective Intrauterine Growth Retardation (SIUGR) Referral Form

UNIVERSITY OF MIAMI MILLER SCHOOL of MEDICINE

Jackson MEMORIAL HOSPITAL — PUBLIC HEALTH TRUST

_____ WORKING IN ASSOCIATION _____

PATIENT INFORMATION

Name _____ , _____ (Last, First)

DOB (MM/DD/YY) ____ / ____ / ____

SSN ____ - ____ - ____

Address _____

Phone ____ - ____ - ____

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

Cell ____ - ____ - ____

E-mail _____

Fax ____ - ____ - ____

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

Employer Address _____

Mother's Maiden Name _____ **Race** _____ **Country of Birth** _____

Religion _____ **Marital Status** _____

Emergency Contact/Next of Kin _____ **Relationship** _____

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

INSURANCE INFORMATION

Patients relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other **Insurance Povider** _____

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

DOB (MM/DD/YY) ____ / ____ / ____ **Group #** _____

SSN ____ - ____ - ____ **Insurance Phone** ____ - ____ - ____

PHYSICIAN INFORMATION

Referring Perinatologist _____ , _____ (Last, First) **Phone** ____ - ____ - ____

Fax ____ - ____ - ____

Physician Address _____

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

E-mail _____

Referring Ob/Gyn _____ , _____ (Last, First) **Phone** ____ - ____ - ____

Fax ____ - ____ - ____

Physician Address _____

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

E-mail _____

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

Submit by Email | Print Form

Date (MM/DD/YY) ____ / ____ / ____

FOR UM/JMH FTC USE ONLY:

Date Received (MM/DD/YY) ____ / ____ / ____ **Diagnosis** _____

Recommendation _____ **Follow Up** _____

MEDICAL INFORMATION

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Jackson MEMORIAL HOSPITAL — PUBLIC HEALTH TRUST

_____ WORKING IN ASSOCIATION _____

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

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

☐ **Twins** ☐ **Triplets** **Maternal Weight** ____ lbs **Placental Location:** ☐ **Anterior** ☐ **Fundal** ☐ **Posterior**

Amniotic Fluid

	DONOR	RECIPIENT
Maximum vertical pocket	_____ cm	_____ cm
Estimated fetal weight	_____ g	_____ g

Cervical Length

Cervical length via transvaginal ultrasound: _____ cm

Funneling? ☐ **Yes** ☐ **No**

Amniocentesis

Genetic ☐ **Yes** ☐ **No** **If yes, karyotype** ☐ **46, XX** ☐ **46, XY** ☐ **Unk**

Therapeutic ☐ **Yes** ☐ **No** **If a therapeutic amniocentesis has been performed, please provide the following information:**

Date MM/DD/YY	Amount Removed	Fluid Color	Placenta Penetrated	Outer Membrane Detachment	Disruption of dividing membrane	Gross Rupture of Membranes (PROM)	Chorio-Amnionitis	Placental Abruption
			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Genetic Screening:

NT Screen ____ : ____ **Down Syndrome** ____ : ____ **Trisomy 13/18** ____ : ____

Quad screen ONTD ____ : ____ **Down Syndrome** ____ : ____ **Trisomy 13/18** ____ : ____

Chorionicity

☐ **Mono/Di** ☐ **Di/Di** ☐ **Unk**

☐ **Mono/Mono** ☐ **Di/Tri**

Doppler Studies

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

Donor urinary bladder visible? ☐ **Yes** ☐ **No**

Fetal Hydrops

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

Abnormal Intracranial U/S Findings

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

Incompetent Cervix

History of an incompetent cervix? ☐ **Yes** ☐ **No**

Cerclage in current pregnancy? ☐ **Yes** ☐ **No**

Pre-term Labor

Symptoms of pre-term labor? ☐ **Yes** ☐ **No**

List symptoms _____

Medications for pre-term labor administered? ☐ **Yes** ☐ **No**

List medications _____

Medical History

Please list any pertinent medical conditions, including bleeding disorders

_____

Medications

_____

How did you hear about us?

☐ **Referral**

Name? _____

☐ **Website**

☐ **Insurance provider list**

☐ **Media**

☐ **Brochure/flyer/mailing**

☐ **Other**