## **University of Miami/Jackson Memorial Hospital Fetal Therapy Center**



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

EDICINE		IIII IIIIOOT			
J	MEMORIAL HOSPITAL				
wo	RKING IN ASSOCIATION				

PATIENT INFORMATION			
Name			DOB (MM/DD/YY) / /
Last Address		First	SSN
City	State	ZIP	Phone
E-mail			
Employer	Wor		
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 Ins	surance Povider
If other than self: Primary subscriber	name?	Po	licy#
DOB (MM/DD/YY)	/ /	Gre	oup #
SSN -		— Ins	surance Phone
PHYSICIAN INFORMATION			
Referring Perinatologist			Phone
melerring Permatologist	Last	/First	Fax
Physician Address			
City	State	ZIP	
E-mail			
Referring Ob/Gyn			Phone
	Last	/First	
Physician Address			<u> </u>
City	State	ZIP	
E-mail			
PLEASE READ BEFORE SUBMISSION: If using Adobe Acrobat Pro, submit by email. If using Adobe Reader, please	PLEASE SUBM	MIT BY EMAIL OR PRINT	FORM AND FAX TO (305) 357-5675
print the form and fax.	Submit by Er	mail Print Form	Date (MM/DD/YY) / /
FOR UM/JMH FTC USE ONLY:			
Date Received (MM/DD/YY)	/ /	Diagnosis	
Recommendation	· —	Follow Up	

## **MEDICAL INFORMATION**

Twins Triplets

**Maximum vertical pocket** 

**Estimated fetal weight** 

GRAV

Yes

**Amount** 

Removed

Yes

/ /

**PARITY** 

No

No

Fluid

Color

Maternal Weight \_\_\_ lbs

**Placenta** 

**Penetrated** 

No

No

Yes

Yes

**DONOR** 

LMP / /

**Outer Membrane** 

**Detachment** 

No

No

Yes

Yes

cm

**RECIPIENT** 

**EDC** 

cm

dividing

membrane

Yes

DATE (MM/DD/YY)

**Amniotic Fluid** 

**Amniocentesis** 

Genetic

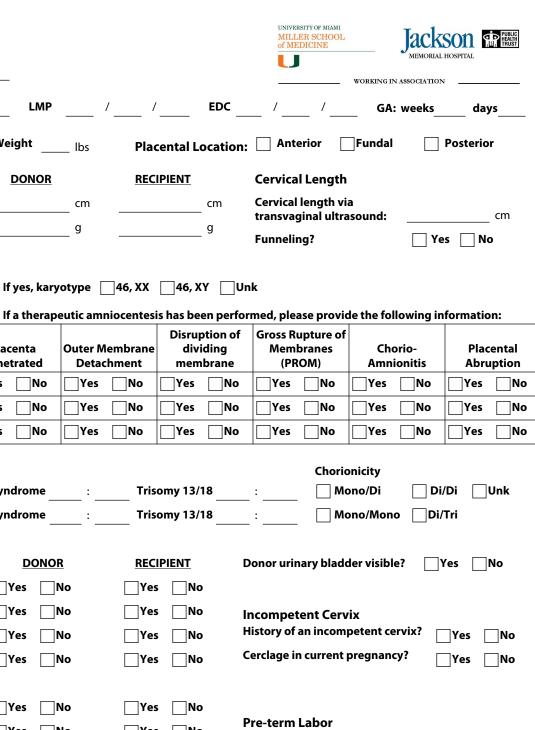
**Date** 

MM/DD/YY

Medications

**Therapeutic** 

**AGE** 



Brochure/flyer/mailing

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Other

	Yes No Yes	No Yes N	lo Yes No Yes No Yes N
Genetic Screening:			Chorionicity
NT Screen : Do	own Syndrome :	Trisomy 13/18	: Mono/Di Di/Di Unk
Quad screen : Do	own Syndrome :	Trisomy 13/18	: Mono/Mono Di/Tri
Doppler Studies	<b>DONOR</b>	RECIPIENT	Donor urinary bladder visible? Yes No
Umbilical artery: AEDV	Yes No	Yes No	
REDV	Yes No	Yes No	Incompetent Cervix
Ductus Venosus-Reverse Flow	Yes No	Yes No	History of an incompetent cervix? Yes No
Umbilical vein pulsatile	Yes No	Yes No	Cerclage in current pregnancy? Yes No
Fetal Hydrops			
Abdominal ascites	Yes No	Yes No	
Scalp edema	Yes No	Yes No	Pre-term Labor
Pleural effusion	Yes No	Yes No	Symptoms of pre-term labor? Yes No
Pericardial effusion	Yes No	Yes No	List symptoms
Abnormal Intracranial U/S Find	lings		Medications for pre-term labor Yes No administered?
Intraventricular hemorrhage	Yes No	Yes No	List medications
Porencephalic cysts	Yes No	Yes No	List medications
Ventriculomegaly	Yes No	Yes No	
Medical History		How did y	ou hear about us? Insurance provider list
Please list any pertinent medical conditions, including bleeding disorders			Media

Name?

Website

TTTS/SIUGR Referral Form - Rev 08/09