

LOS ANGELES FETAL SURGERY
TWIN-TWIN TRANSFUSION SYNDROME (TTTS) /
SELECTIVE INTRAUTERINE GROWTH RESTRICTION (SIUGR)
REFERRAL FORM



Los Angeles Fetal Surgery

DATE ____/____/____

PATIENT NAME _____ DOB ____/____/____
(Last) (First) (Middle)

PATIENT CELL PHONE (____) ____-____ EDC ____/____/____ EGA _____ WEIGHT _____

INSURANCE _____ INSURANCE ID# _____

REFERRING MFM _____ MFM CELL PHONE (____) ____-____
(First) (Last) (Title) (Optional)

MFM OFFICE PHONE (____) ____-____ MFM OFFICE FAX (____) ____-____

MFM OFFICE ADDRESS _____
(Street) (Suite #) (City) (State) (Zip Code)

PRIMARY OB _____
(First) (Last) (Title)

OB OFFICE PHONE (____) ____-____ OB OFFICE FAX (____) ____-____

OB OFFICE ADDRESS _____
(Street) (Suite #) (City) (State) (Zip Code)

- DIAGNOSIS** TTTS - Monochorionic twin pregnancy with maximum vertical pocket $\leq 2\text{cm}$ in the Donor and $\geq 8\text{cm}$ in the Recipient. The Donor may or may not have a visible bladder. Size discordance is not necessary.
- SIUGR - One fetus is $< 10^{\text{th}}$ percentile while the other fetus is appropriately grown (AGA). Although amniotic fluids may be discordant, they do not meet the criteria for TTTS ($\leq 2\text{cm}$ and $\geq 8\text{cm}$). Our protocol for laser surgery for SIUGR requires **absent or reverse flow** in the umbilical artery.

ULTRASOUND DATE ____/____/____

PLACENTA LOCATION Anterior Posterior Fundal

MULTIPLES Twins Triplets Quadruplets

CHORIONICITY Mono/Di Mono/Mono Other: _____

AMNIOTIC FLUID Maximum Vertical Pocket in each sac: Recipient _____ cm Twin A or B (select one)
Donor _____ cm Twin A or B

FETAL WEIGHT EFW Measurements: Recipient _____ grams _____%
Donor _____ grams _____%

FETAL BLADDER Donor fetus urinary bladder: Filling Not Filling

RECIPIENT**DONOR****FETAL HYDROPS**

Scalp / Skin Edema
 Pleural Effusion
 Pericardial Effusion
 Ascites

Yes No
 Yes No
 Yes No
 Yes No

Yes No
 Yes No
 Yes No
 Yes No

DOPPLER STUDIES

Umbilical Artery: AEDV
 REDV
 Umbilical Vein - Pulsatile Flow
 Ductus Venosus - Reverse Flow

Yes No
 Yes No
 Yes No
 Yes No

Yes No
 Yes No
 Yes No
 Yes No

CERVICAL LENGTH

Cervical length _____ cm

Has a cerclage been performed? Yes No

FETAL ANOMALIES

Yes No

Comments _____

GENETIC SCREENING

1st Trimester Yes No

Results: _____

NT Yes No

Results: _____

2nd Trimester Yes No

Results: _____

NIPT Yes No

Results: _____

DIAGNOSTIC TESTING

CVS Yes No Date ___/___/___

Results: _____

Amniocentesis Yes No Date ___/___/___

Results: _____

PRETERM LABOR

Has this patient experienced any symptoms of preterm labor? Yes No

Have any medications for preterm labor been administered? Yes No

List: _____

AMNIORREDUCTION

Has an amnioreduction been performed? Yes No

Date ___/___/___

Volume extracted _____ mL

Date ___/___/___

Volume extracted _____ mL

MEDICAL HISTORY

Is the patient taking Aspirin? Yes No

Please list any pertinent maternal medical conditions _____

PLEASE FAX FORM TO: (213)469-6279

PLEASE ATTACH:

- Patient demographic information
- Insurance information
- Prenatal records
- Recent consultation letters and ultrasounds reports

Please contact our office at **(213)469-6277** if you need help with the insurance authorization process.

Arlyn Llanes, RN and Kris Rallo, RN are available to answer questions by phone at **(213)469-6277** or by email at

Arlyn.Llanes@med.usc.edu or Kristine.Rallo@med.usc.edu.