



DATE ____ / ____ / ____

PATIENT NAME

(Last)

(First)

(Middle)

DOB ____ / ____ / ____

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

INSURANCE _____ INSURANCE ID# _____

REFERRING MFM

(First)

(Last)

(Title)

MFM CELL PHONE (____) ____ - ____

(Optional)

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

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

PRIMARY OB

(First)

(Last)

(Title)

OFFICE PHONE (____) ____ - ____

SUSPECTED DIAGNOSIS

Vasa Previa

☐ Type I

☐ Type II

☐ Type III

ULTRASOUND

DATE ____ / ____ / ____

DIAMETER OF VASA PREVIAVESSEL _____

MORE THAN 4MM? ☐ Yes ☐ No

INSERTS NEAR CERVIX? ☐ Yes ☐ No

PLACENTAL CORD INSERTION SITE _____

PLACENTA LOCATION ☐ Anterior ☐ Posterior ☐ Fundal

MULTIPLES ☐ Singleton ☐ Twins ☐ Triplets ☐ Other: _____

CHORIONICITY ☐ Di-Di ☐ Mono-Di ☐ Mono-Mono ☐ Other: _____

AMNIOTIC FLUID VOLUME Maximum Vertical Pocket: _____ cm

OTHER FETAL ANOMALIES _____

CERVICAL LENGTH Cervical length _____ cm

Has a cerclage been performed? ☐ Yes ☐ No

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: _____

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.