



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)

OFFICE PHONE (____) _____ - _____ **OFFICE FAX** (____) _____ - _____

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

PRIMARY OB _____ **OFFICE PHONE** (____) _____ - _____
(First) (Last) (Title)

PRIMARY INDICATION Anemia Thrombocytopenia Mosaicism Other: _____

Suspected Diagnosis: _____

ULTRASOUND DATE ____/____/____

PLACENTA LOCATION Anterior Posterior Fundal

FETAL WEIGHT Most recent estimated fetal weight measurement: _____ grams _____%

AMNIOTIC FLUID Maximum Vertical Pocket: _____ cm

ABNORMALITIES Structural Anomalies Yes No Comments: _____
Fetal Hydrops Yes No Comments: _____

CERVICAL LENGTH Cervical length _____ cm
Has a cerclage been performed? Yes No

MCA PSV MEASUREMENTS Please list Middle Cerebral Artery (MCA) peak systolic velocities:

Date ____/____/____	GA _____	MCA psv _____ cm/s	MoM _____
Date ____/____/____	GA _____	MCA psv _____ cm/s	MoM _____
Date ____/____/____	GA _____	MCA psv _____ cm/s	MoM _____
Date ____/____/____	GA _____	MCA psv _____ cm/s	MoM _____

OBSTETRICAL HISTORY Number of previously affected pregnancies: _____
Outcomes of previously affected pregnancies: _____

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 _____
Cordocentesis 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.