Keck Medicine of USC

TWIN-TWIN TRANSFUSION SYNDROME (TTTS) SELECTIVE INTRAUTERINE GROWTH RESTRICTION (SIUGR) REFERRAL FORM



DATE		MATERNAL WEIGHT							
PATIENT	D()B	CELL PHONE						
PHYSICIAN	ED	C	_EGA	Twins	_ Triplets				
PHYSICIAN PHONE		FAX							
PHYSICIAN ADDRESS									
CITY/STATE	INSURANCI	E							
<u>SIUGR</u> is defined as one fetus being l amniotic fluids may	or may or may not have a visible	bladder. Size di the other fetus i the criteria for T	scordance is a sappropriate TTS. (\le 2cm	not necessary. ly grown (AG and ≥8cm.).	A). Although				
PLACENTA LOCATION PRIM	MARILY Anterior	Post	terior						
CHORIONICITYMono/D	iMono/Mono	Di/Di		Unknown					
AMNIOTIC FLUID Maximum	Vertical Pocket in each sac:	Recipient Donor	•						
WEIGHT DISCORDANCE Fe	tal Weight Measurements:	Recipient grams Donor grams							
FETAL BLADDER The urinary b	pladder in the Donor fetus app	ears to be:	_ Filling	Not F	Filling				
FETAL ANOMALIES Yes	No Comments								
ABNORMAL INTRACRANIAL	II/S FINDINGS	RECIP	TENT	DON)R				
Does either fetus have evidence of:	Intraventricular Hemorrhage Porencephalic Cysts Ventriculomegaly	Yes Yes Yes	No No No	Yes Yes Yes	No No No				
FETAL HYDROPS Does either fetus have evidence of:	Scalp Edema Pleural Effusion Pericardial Effusion Ascites	YesYesYesYes	NoNoNoNo	Yes Yes Yes Yes	No				
DOPPLER STUDIES	ASCIES		110	168	110				
Does either fetus have evidence of:	Umbilical artery: AEDV REDV Ductus Venosus- Reverse Fl Umbilical Vein- Pulsatile Flo	Vac	No No No	Yes Yes Yes	No No No No				

CERVICAL .	LENGTH-I	REQUI	<u>RED</u>											
Via endovagi If cervix me						o measu	re	cm	Funne	ling? _	Ye	es	_No	
1 st and/or 2 nd	TRIMEST	ER SCR	EEN											
				increa	sed risk	for I	Down's S	Syndron	ne?	Ves	N	0		
If this test has been done is there an increased risk for:							Neural tube defect?Ye							
AMNIOCEN	TESIS					1	vourar ea	oc dere		105		J		
	patient unde	roone an	v amni	ocente	esis nroc	edures'	?	Genetic	r	Ther	neutic		None	.
•	etic amnioce	•	•		-						-			
	apeutic (deco													
Date of Amo	Amount Removed	Fluid Color			Outer Membrane Detachment		Disruption of dividing membrane (Septostomy)		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
INCOMPET	ENT CERV	<u>VIX</u>												
Does this patient have a history of an incompetent cervix?						? _	Y	Zes .		_ No				
Has a ce	rclage suture	e been pe	erforme	ed with	this pro	egnanc	y? _	Y	es		_ No			
PRETERM 1	LABOR													
Has this patient experienced any symptoms of preterm labor?						Yes			_ No					
Have any medications for preterm labor been administered?						ed? _	Yes			_ No				
List:												-		
MEDICAL I	HISTORY													
Please li	st any pertin	ent mate	rnal m	edical	conditio	ons (i.e.	diabete	s, hvper	tension.	. lupus	. CHD.	etc.)		
	• •					·				•		-		
												-		
PLEASE F	AX FOR	м то	: (626	<u>()</u> 356	-3379									
Insurance autho or by email at <u>A</u>								N, who m	ay be co	ntacted	by phon	ie at <u>(62</u>	<u>26)356-3</u>	<u>360</u> ,
Internal office u	ise:													
DATE RECEIV							DL	AGNOSIS						
RECOMMENDATION														