



**REQUEST FOR FETAL CARDIAC IMAGING AND CONSULTATION**

***PLEASE COMPLETE REQUIRED INFORMATION BELOW:***

Date: \_\_\_\_\_ Mother's Name: \_\_\_\_\_ Mother's Date of Birth: \_\_\_\_\_

Phone #: \_\_\_\_\_ Cell/Work #: \_\_\_\_\_

Insurance/Medicaid Plan: \_\_\_\_\_ Policy & Group #: \_\_\_\_\_

Additional Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

If available & **legible**, please also fax copy of insurance card

**OBSTETRICAL HISTORY:**

Mother's EDD: \_\_\_\_\_ Maternal obesity (BMI >40)? Y / N Multiple gestation? Y / N  
If multiple, # of fetuses \_\_\_\_\_

**\*\*\*Is this an early gestation (14-16 weeks EGA) fetal echocardiography request? Y / N**

**INDICATION FOR REFERRAL (SPECIFY BELOW):**

**SCREENING STUDY**

**Specify:**

- Maternal diabetes
- FHx of CHD
- Single UA
- IVF pregnancy
- Chromosomal abnormality
- Echogenic intracardiac focus

Extracardiac fetal anomaly (specify):  
\_\_\_\_\_

**Other (specify):**  
\_\_\_\_\_

**SUSPECTED STRUCTURAL/  
CONGENITAL HEART DEFECT**

**Specify:**

- Single ventricle
- Hypoplastic left heart
- RV/LV size discrepancy
- Transposition of the great arteries
- Tetralogy of Fallot
- Double-outlet RV
- AV canal defect
- Ventricular septal defect
- Atrial septal defect

**Other/complex defect (specify):**  
\_\_\_\_\_

**SUSPECTED FETAL CARDIAC  
ARRHYTHMIA OR CARDIAC  
FAILURE/DYSFUNCTION**

**Specify:**

- Fetal tachycardia
- Fetal bradycardia/heart block
- Other arrhythmia
- Cardiomegaly
- Ventricular dysfunction
- Hydrops
- TTTS
- Fetal anemia
- Atrial septal defect

**Other (specify):**  
\_\_\_\_\_

**PLEASE INCLUDE THE FOLLOWING DOCUMENTS BELOW:**

- Demographic Information     Insurance Information     Last Ultrasound Report     Last Clinical Notes

**\*\*ANY RECORDS THAT INCLUDE MATERNAL MEDICAL HISTORY, SOCIAL HISTORY, PAST MEDICAL HISTORY\*\***

**REFERRING PHYSICIAN: (Ordering Physician Signature (REQUIRED))**

Print MD Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_

**Referring MD specialty (please specify):**

- MFM/Perinatologist     Obstetrician     Cardiologist

**FOR CHILDREN'S CARDIOLOGY STAFF ONLY**

Date and Time of Appointment: \_\_\_\_\_

Location: \_\_\_\_\_ MD: \_\_\_\_\_