Children's Healthcare of Atlanta
Cardiology

Fetal Cardiac Program
404-256-2593 (ext. 8012)
800-542-2233 (ext. 8012)
Fax: 770-488-9404

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:_____

Payor Referral 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

All screening studies will be scheduled within 4 weeks unless otherwise specified

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

Please indicate timing for evaluation below

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 (specify): _____

SUSPECTED FETAL CARDIAC ARRHYTHMIA OR CARDIAC FAILURE/DYSFUNCTION

All indications below require a STAT visit unless otherwise specified

Specify:

□ Fetal tachycardia
□ Fetal bradycardia/heart block
□ Other arrhythmia
□ Cardiomegaly
□ Ventricular dysfunction
□ Hydrops
□ TTTS
□ Fetal anemia

Other (specify): _____

REQUEST TIMING OF EVALUATION:

□	□ Urgent visit (within 1-2 weeks)	□ STAT visit (within 1-2 days)

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: _____