



22474-45

# Children's Healthcare of Atlanta

## REQUEST FOR FETAL CARE CENTER CONSULTATION

Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

MRN# \_\_\_\_\_

Account/HAR# \_\_\_\_\_

PATIENT IDENTIFICATION

Date of Referral: \_\_\_\_\_

### Please provide the following Maternal information:

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Preferred Phone #: \_\_\_\_\_ Other contact #: \_\_\_\_\_

Mother's Email Address: \_\_\_\_\_

### Maternal History:

EDD: \_\_\_\_\_ Anticipated Delivery Hospital: \_\_\_\_\_ Multiple Gestation: Yes/No

Maternal complications or morbidities: \_\_\_\_\_

Pertinent Maternal labs or studies (including genetic testing): \_\_\_\_\_

Imaging Done: (please include reports if not performed by CHOA/Children's Cardiology)

**MRI**

Date performed \_\_\_\_\_ Location: \_\_\_\_\_

Pertinent findings: Material BMI \_\_\_\_\_ AFI \_\_\_\_\_

**Echo**

Date of last Echo \_\_\_\_\_

### Indication for Referral: (Please check all that apply)

Pulmonary/Airway	CNS	ENT/Airway
<ul style="list-style-type: none"> <li><input type="checkbox"/> Bronchogenic cyst/Congenital lung lesion</li> <li><input type="checkbox"/> Bronchopulmonary sequestration</li> <li><input type="checkbox"/> Congenital diaphragmatic hernia</li> <li><input type="checkbox"/> Other _____</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Neural tube defect</li> <li><input type="checkbox"/> Ventriculomegaly</li> <li><input type="checkbox"/> Schizencephaly</li> <li><input type="checkbox"/> Lissencephaly</li> <li><input type="checkbox"/> Abnormal posterior fossa/suspected dandy-walker malformation</li> <li><input type="checkbox"/> Other _____</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Cervical teratoma</li> <li><input type="checkbox"/> Airway obstruction</li> <li><input type="checkbox"/> Microstomia</li> <li><input type="checkbox"/> Cystic hygroma</li> <li><input type="checkbox"/> Other _____</li> </ul>
Renal/Urologic/GU	GI/Abdominal	Other
<ul style="list-style-type: none"> <li><input type="checkbox"/> Bladder exstrophy</li> <li><input type="checkbox"/> Bladder outlet obstruction</li> <li><input type="checkbox"/> Hydrocolpos</li> <li><input type="checkbox"/> Hydronephrosis</li> <li><input type="checkbox"/> Multicystic dysplastic kidneys</li> <li><input type="checkbox"/> Renal agenesis/severe 'oligo' hydramnios</li> <li><input type="checkbox"/> Ovarian Cyst</li> <li><input type="checkbox"/> Prune belly syndrome</li> <li><input type="checkbox"/> Other _____</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Bowel obstruction</li> <li><input type="checkbox"/> Choledochal cyst</li> <li><input type="checkbox"/> Duodenal atresia</li> <li><input type="checkbox"/> Esophageal atresia</li> <li><input type="checkbox"/> Gastroschisis</li> <li><input type="checkbox"/> Imperforate anus</li> <li><input type="checkbox"/> Omphalocele</li> <li><input type="checkbox"/> Liver mass</li> <li><input type="checkbox"/> Other _____</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Conjoined twins</li> <li><input type="checkbox"/> Fetal hydrops</li> <li><input type="checkbox"/> Sacrococcygeal teratoma</li> <li><input type="checkbox"/> Twin to twin transfusion</li> <li><input type="checkbox"/> VACTERL association</li> <li><input type="checkbox"/> Chromosomal abnormality: Specify: _____</li> <li><input type="checkbox"/> Hemangioma/Lymphatic malformation</li> <li><input type="checkbox"/> Family history of significant genetic/metabolic disorder</li> </ul>

Cardiac – Children's Cardiology referral done? Y/N

Cardiac diagnosis: \_\_\_\_\_



22474-45

Children's Healthcare of Atlanta

**REQUEST FOR FETAL CARE  
CENTER CONSULTATION**

Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

MRN# \_\_\_\_\_

Account/HAR# \_\_\_\_\_

PATIENT IDENTIFICATION

Request for coordination of (Please check all that apply):

- Consultation with surgeon/subspecialist
- Neonatology consultation
- Family tour of CHOA NICU
- Fetal MRI –see attached for list of indications

Campus Preference (Optional):

- Arthur M. Blank (select for patients with cardiac defect or possible need for ECMO)
- Scottish Rite
- No preference

Name of preferred general or specialty surgery provider (Optional):

\_\_\_\_\_

Other requests: \_\_\_\_\_

**PLEASE INCLUDE THE FOLLOWING DOCUMENTS:**

- Demographic Information
- Insurance Information
- Last Ultrasound
- Last Clinical Note

**REFERRING/ORDERING PHYSICIAN (Required):**

Printed Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_

Name of Practice: \_\_\_\_\_

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

Email: \_\_\_\_\_ Contact Number: \_\_\_\_\_ Fax: \_\_\_\_\_

Referring Provider Specialty:

MFM/Perinatologist Obstetrician Y/N Other: \_\_\_\_\_

Children's Healthcare of Atlanta Fetal Care Center

[fetalcare@choa.org](mailto:fetalcare@choa.org)

o: 404-785-3916

f: 404-553-9751