UCSF Benioff Children's Hospital

Fetal Cardiovascular Program

Anita Moon-Grady, MD
Michael Brook, MD
Mark Cocalis, MD
Alaina Kipps, MD

Phone: (415) 353-1887
Fax: (415) 353-8675
www.fetalheart.org

Request for Fetal Echocardiogram

*Please send completed form by fax **(415) 353-8675** or email **fetalheart@ucsf.edu**. This form is for cardiac/echo referral only.*
For additional Fetal Treatment services please contact the Fetal Treatment Center 1-800-RX-FETUS (1-800-793-3887)

Date of Referral _____ (mm/dd/yyyy)

Patient Name _____ (Last) _____ (First)

Date of Birth _____ (mm/dd/yyyy)

Patient Contact Info

Address _____

_____ (City) _____ (State) _____ (Zip Code)

Home ( ) _____

Work ( ) _____

Mobile ( ) _____

Obstetrical History

G _____ P _____ TAB _____ SAB _____ IUFD _____

Gestational Age Today _____ weeks _____ days

LMP _____ (mm/dd/yyyy) EDC _____ (mm/dd/yyyy)

Indication for Referral

- ☐ Increased NT (_____ mm)
- ☐ Family History
- ☐ Diabetes (Type or White Class _____)
- ☐ Maternal SSA/SSB
- ☐ Fetal Arrhythmia
- ☐ Known Chromosome Abnormality
- ☐ ART/IVF _____
- ☐ Other (Specify _____)

Additional Fetal Treatment Indications*

- ☐ Twin Twin Transfusion Syndrome
- ☐ Suspected Abnormality of the Heart
- ☐ Other Abnormalities (Specify _____)

** If your patient needs additional Fetal Treatment services contact the Fetal Treatment Center at 1-800-RX-FETUS to coordinate the fetal echo and other appointments .*

Diagnostic Information

Amino ☐ N/A Date _____ (mm/dd/yyyy)

Results _____

Ultrasound ☐ N/A

Results _____

Maternal Serum Screen ☐ N/A

Results _____

Primary/Referring OB (non-UCSF)

Name _____ (Last) _____ (First)

Address _____

_____ (City) _____ (State) _____ (Zip Code)

Phone ( ) _____

Fax ( ) _____

Referring Physician (UCSF)

Name _____ (Last) _____ (First)

Phone ( ) _____

Pager ( ) _____

Insurance Preauthorization

If your patient requires insurance preauthorization, please fax or send the confirmation to us prior to the appointment date.

Fetal Echo & Consultation Codes:
76825, 76827, 76820, 93325, 99244

UCSF Staff Only

Date of Scheduled Fetal Echo _____ (mm/dd/yyyy)

Gestation at Scheduled Echo _____

Reviewed by _____ Date _____ (mm/dd/yyyy)

Comments _____