UPMC CHILDREN'S HEART INSTITUTE

Fetal and Perinatal Cardiology Program
Phone: 412-641-4304
Fax: 724-786-7735
Email: perinatalcardiology@upmc.edu

Referral Form – Fetal and Perinatal Cardiology Imaging and Consultation

The following information is needed to ensure your patient is scheduled appropriately. Please include patient demographic information, a copy of insurance card, echo script, and clinic records including office visit, OB ultrasound report, and genetic testing. If you have any questions regarding this form, please call our office at 412-641-4304 and ask to speak with our nurse coordinator.

Mother's name/ (maiden name): _____ Mother's DOB: _____

Phone #: _____ **Insurance: (please include copy- font and back of card)**

Additional Contact: _____ Relationship: _____ Contact #: _____

Obstetrical History:

EDD: _____ Maternal Obesity (BMI> 40)? Y / N Weight/ BMI: _____/_____

Multiple gestation? Y / N If multiples, # of fetuses? _____

Reason for Referral

Screening Study

☐ Maternal diabetes
☐Family history of CHD (1st degree relative to fetus, i.e. parent or sibling)
Relationship/type: _____
☐ Non-visualized cardiac views
☐ Abnormal genetic screening/testing in fetus
☐ Increased nuchal translucency > 3.5mm
☐ Monochorionic twins
☐ Autoimmune disease: SSA/SSB positive
☐ High-risk maternal medication exposure:
- ☐ Retinoids
- ☐ Lithium
- ☐ ACE inhibitors
- ☐ NSAIDs
- ☐ Paroxetine

☐ IVF (may be considered)

Fetal Cardiac Anomaly or Arrhythmia

☐ Cardiac anomaly identified on OB ultrasound
- ☐ Type: _____

☐ Extracardiac anomalies on OB anatomy scan
☐ Fetal arrhythmia
- ☐ Sustained
- ☐ Intermittent

☐ Fetal heart block
☐ Hydrops or pericardial effusion
☐ Cardiomegaly
☐ TTTS

REFERRING PHYSICIAN: (please include echo script if not placed in UPMC EPIC EMR)

Print MD Name: _____ Signature: _____ Date: _____

Address: _____ Phone: _____Fax: _____ E-mail: _____

Referring MD specialty (please specify):

□ MFM/Perinatologist □ Obstetrician □ Cardiologist