Stanford Children's Health | Lucile Packard Children's Hospital Stanford

Lucille Salter Packard Children's Hospital
STANFORD UNIVERSITY MEDICAL CENTER ● 725 Welch Road, Palo Alto, CA 94304

ORDER • FETAL ECHOCARDIOGRAM

Medical Record Number

Patient Name

Addressograph Stamp – Patient Name, Medical Record Number

Physician: Check all orders that pertain to the patient. Date, time & sign all orders.

Please specify the priority of your request:

- ☐ Urgent
- ☐ ASAP
- ☐ Routine, please schedule for________weeks GA

This is for a:

- ☐ Singleton
- ☐ Multiple Gestation: Twin, Triplet

Obstetrical History:

EDC: ___________________

Gestational age today_____wks _____days

G_____P______TAB______SAB______IUFD ______

Genetic Screening or Testing:

- ☐ Prenatal Screening ______________________
- ☐ Cell free fetal DNA/NIPT_________________
- ☐ Amniocentesis/CVS_________________________

Indications for Referral:

- ☐ Suspected cardiac abnormality:_________________________________
- ☐ Increased Nuchal Translucency, NT:____________mm
- ☐ Fetal Cardiac Arrhythmia
- ☐ Extra cardiac anomaly: _________________________
- ☐ Known or suspected chromosomal abnormality: ____
- ☐ Maternal diabetes: Type2_____Type 1 _____ GDM(HbA1c>6%) __________
- ☐ Assisted reproductive technology, IVF
- ☐ Family history of CHD. Please provide details if available: ____
- ☐ Maternal SSA+/SSB+ autoantibodies (Lupus, Sjogrens Syndrome). Please include labs if possible.
- ☐ Exposure to maternal medication or teratogenic substance: ____
- ☐ Monochorionic twinning
- ☐ Other:_____________________________________

**If your patient's insurance requires preauthorization, please contact them for authorization with confirmation faxed or sent to this department

- ☐ **Walnut Creek** P: 925-295-1701/F: 925-295-1704
- ☐ **Emeryville** P: 925-295-1701/F: 925-295-1704
- ☐ **Modesto** P: 209-672-6377/F: 209-672-6378

☐ Referral

Assume present and future (if needed) management of this patient, restricted to area of fetal cardiology.
Patient will return to OB/MFM Office for all other aspects of care. Ongoing cardiology evaluation (when needed) will be ordered by fetal cardiologist.

☐ Consultation (one visit)

_______ With fetal echocardiogram
_______ Without fetal echocardiogram

Patient will return to OB/MFM Office for all aspects of care, and future cardiology consultations will require new request.

Referring Physician Contact Information:

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____
____

Phone______________________________________

Fax____

Please cc/send additional report to:

____
____
____

Phone______________________________________

Fax____

DATE	TIME	Provider Signature:	Pager:	Noted by:	Date/Time
Orders signed		**PRINT** Provider Name:		RN Signature	Date/Time