USF HEALTH

FETAL CARE CENTER OF TAMPA BAY REFERRAL QUESTIONAIRE
TWIN TWIN TRANSFUSION SYNDROME (TTTS)
Please fax this form, sono report and prenatals including demographics to: #(813) 259-0839
e-mail: szientara@tgh.org or call the Fetal Care Center phone: (813) 259-8513

Date_____

Patient_____Maternal Height_____Weight_____

Referring Physician_____ Best contact phone #_____

Address_____Phone_____

Fax_____

City_____ State_____ Zip_____

TTTS defined as a monochorionic twin pregnancy with a Maximum Vertical Pocket <2cm in the Donor and >Scm in the
Recipient. The Donor may or may not have a visible bladder. Size discordance is no longer considered a criteria.
IUGR is defined as one fetus being less than the lath percentile while the other fetus is appropriately grown (AGA). Although amniotic fluids
may be discordant, they do not meet the criteria for TTTS. (<2cm and >Scm.). Our protocol for laser surgery for SIUGR requires
absent or reverse flow in the umbilical artery.

PLACENTA LOCATION _____ANTERIOR _____POSTERIOR

CHORIONICITY _____MONO/DI _____MONO/MONO _____DI/DI _____UNKNOWN

AMNIOTIC FLUID (maximum vertical pocket in each sac)   Recipient/AGA _____ cm
                                                          Donor/IUGR   _____ cm

WEIGHT DISCORDANCE: Fetal Weight Measurements   Recipient/AGA _____grams
                                                          Donor/IUGR   _____grams

FETAL BLADDER
    The urinary bladder in the Donor/IUGR fetus appeared to be:_____Filling _____Not Filling

FETAL ANOMOLIES _____YES _____NO COMMENTS_____

ABNORMAL INTRACRANIAL U/S FINDINGS

		RECIPIENT	DONOR
Does either fetus have evidence of:	Intraventricular hemorrhage	_____Yes _____NO	_____Yes _____NO
	Porencephalic cysts	_____Yes _____NO	_____Yes _____NO
	Ventriculomegaly	_____Yes _____NO	_____Yes _____NO

FETAL HYDROPS

		RECIPIENT	DONOR
Does either fetus have evidence of:	Abdominal ascites	_____Yes _____NO	_____Yes _____NO
	Scalp Edema	_____Yes _____NO	_____Yes _____NO
	Pleural Effusion	_____Yes _____NO	_____Yes _____NO

DOPPLER STUDIES

		RECIPIENT	DONOR
Umbilical Artery	AEDV	_____Yes _____NO	_____Yes _____NO
	REDV	_____Yes _____NO	_____Yes _____NO
Ductus Venosus-Reverse Flow		_____Yes _____NO	_____Yes _____NO
Pulsatile Umbilical Vein		_____Yes _____NO	_____Yes _____NO

FETAL ECHO _____YES _____NO   Findings_____

CERVICAL LENGTH(required)
Via transvaginal scanning, the cervical length appeared to measure _____cm   Funneling? _____YES _____NO
                **If Cervix measures <2.5cm a cerclage may be required prior to laser therapy

HAS THE PATIENT HAD SERUM SCREEN TESTING?   _____YES _____NO
     If this test has been done is there an increased risk for:
     Down's Syndrome? _____yes _____no   Neural tube defects: _____yes _____no
     Other_____

HAS THE PATIENT HAD NON-INVASIVE PRENATAL TESTING?   _____YES _____NO
     If this test has been done is there an increased risk for:
     Down's Syndrome? _____yes _____no   Neural tube defects: _____yes _____no
     Other_____

HAS THE PATIENT HAD CVS? _____YES _____NO
     If CVS has been performed, please state the fetal karyotype: _____46, XX _____46, XY   Other:_____

AMNIOCENTESIS
     Has the patient underfone any amniocentesis procedures? _____genetic _____theraputic _____none
     If a genetic amniocentesis has been performed, please state the fetal karyotype: _____46,XX _____46, XY _____other

If a therapeutic (decompression) amniocentesis has been performed, please complete the following:

DATE	AMOUNT REMOVED	FLUID COLOR	PLACENTA PENETRATED	OUTER MEMBRANE DETACHMENT	DISRUPTION OF DIVIDING MEMBRANE	GROSS RUPTURE OF MEMBRANES (PROM)
			YES/NO	YES/NO	YES/NO	YES/NO
			YES/NO	YES/NO	YES/ NO	YES/NO
			YES/NO	YES/NO	YES/NO	YES/NO

INCOMPETENT CERVIX
     Does this patient have a history of an incompetent cervix?   _____YES _____NO

     Has a cerclage suture been performed with this pregnancy?   _____YES _____NO

PRETERM LABOR

     Has this patient experienced any symptoms of preterm labor?   _____YES _____NO

     Have any medications for preterm labor been administered?   _____YES _____NO

     LIST:_____

MEDICAL HISTORY

     Please list any pertinent maternal medical conditions (ie: diabetes, hypertension, lupus, CHD, ect..)

     _____