THE
University of Vermont
MEDICAL CENTER

Fetal Diagnostic Center 1st Trimester ULTRASOUND

Please fill out completely and Fax to **802-847-3698** Questions? Call 802-847-5698

Name____
First Last (Prior/Maiden) MRN Date of Birth

Gravida______ Para___________Phone____
(4-digit) Home Cell

Desired time line for exam_____________ Preferred day/time___________________________

Due Date___________________Height_______________**Pre-** pregnancy weight___________________________
LMP______________________ Cycle length28 days or_____________________days
Ultrasound dating: EGA at ultrasound__________________and date of ultrasound_________________________
IVF date______________(day 3 or 5 day transfer?) IUI date of insertion___________________________________

Reason for scan:

- ☐ AMA
- ☐ Twins or higher
- ☐ Abnormal U/S finding **(FAX RESULTS)**____
- ☐ Family History____
- ☐ Maternal medical condition____
- ☐ Other____
- ☐ Screening for anomaly, no risk factors

Uterine size/dates mismatch
Diabetes

Tobacco/Drug use
Hypertension

Services Requested:

- ☐ Genetic Consult
- ☐ First Trimester scan (76801 or 76817 as appropriate)
- ☐ Ultrascreen - First Trimester Combined Screening **CRL + NT** (76813)
  - Patient had 1st trimester serum drawn in your office (9-11 weeks optimal)
  - Patient will have blood drawn at the Fetal Diagnostic Center at U/S visit
- ☐ Integrated screen – First Trimester Combined Screening **CRL + NT.** 2nd trimester serum needed to complete patient analysis.

(**CRL + NT** measurement w/serum screen (does not include fetal anatomy, other biometry, placental position, maternal anatomy, etc., unless you order a First Trimester scan separately.)

- ☐ CVS (includes a 1st trimester scan, 76801, unless otherwise requested) **Blood Type:**_______________
- ☐ 3D Ultrasound if appropriate for findings
- ☐ **CONSULTATION FOR ABNORMAL ULTRASOUND FINDINGS** or **ABNORMAL ULTRASCREEN RESULTS**
  (This is a MFM consult and/or Genetic counseling performed **ONLY** if there is an abnormal finding.)

Referring Provider:_____________________________**Signature Required:**_______________________________

Office Phone: ___________________________**Office Fax:** _________________________**Contact:**_____________

FOR OUR USE: Ultrasound_________________________________**Office contacted**_________________________

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