THE University of Vermont MEDICAL CENTER

Fetal Diagnostic Center r 2nd/3rd 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 length 28 days or_____days.
Ultrasound dating: EGA at ultrasound_____and date of ultrasound_____
IVF date_____(day 3 or 5 day transfer?) IUI date of insertion_____

Screening: NT QUAD CELL FREE DNA PATIENT HAD NONE

Reason for scan:

- ☐ AMA ☐ Uterine size/dates mismatch ☐ Tobacco/Drug use
- ☐ Twins or higher ☐ Diabetes ☐ Hypertension
- ☐ Abnormal Genetic screening **(FAX RESULTS)**
- ☐ Abnormal U/S finding **(FAX RESULTS)**___
- ☐ Family History_____
- ☐ Maternal medical condition_____
- ☐ Other_____
- ☐ Screening for anomaly, no risk factors

Services Requested:

- ☐ Genetic Counseling
- ☐ OB scan w/Detailed fetal anatomy (76811; for increased risk for fetal abnormality)
- ☐ Routine Obstetrical scan (76805; basic evaluation w/low risk anatomic survey)
- ☐ Follow-up Obstetrical scan (76816; reevaluation of anatomy, growth, etc….)
- ☐ Limited Obstetrical scan (76815; heart rate, placental position, AFI, fetal position)
- ☐ Transvaginal scan (76817; for cervical length)
- ☐ Fetal Echocardiogram w/Doppler studies and color flow map
- ☐ Doppler studies (circle those desired; Umbilical, Middle-cerebral, Uterine)
- ☐ Biophysical Profile(with NST_____without NST_____)
- ☐ Amniocentesis (if scan is also desired, please choose one above) **Blood Type:**_____
- ☐ 3D Ultrasound in appropriate for findings or history
- ☐ **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_____