Stanford MEDICINE
Children's Health

725 Welch Road, Palo Alto, CA 94304

Patient DOB

Patient Contact Information:

Addressograph or Label – Patient Name, Medical Record Number

ORDERS • FETAL ECHOCARDIOGRAM

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

Please specify the priority of your request:

- ❑ ASAP
- ❑ Urgent
- ❑ Routine, please schedule for _____ weeks GA

This is for a:

- ❑ Singleton
- ❑ Multiple Gestation: Twin, Triplet

Obstetrical History:

EDD: _____

Gestational age today _____ wks _____ days

G _____ **P** _____

Genetic Screening or Testing:

- ❑ Cell free fetal DNA/NIPT _____
- ❑ Amniocentesis/CVS _____

Indications for Referral:

- ❑ Suspected cardiac abnormality:

  _____
- ❑ Increased Nuchal Translucency, NT: _____mm
- ❑ Fetal Cardiac Arrhythmia, please provide details:

  _____
- ❑ Known or suspected genetic abnormality:

  _____
- ❑ Maternal diabetes: Type 2 _____ Type 1 _____

  GDM(HbA1c>6%) _____
- ❑ Assisted reproductive technology, IVF
- ❑ Family history of CHD. Please provide details if available:

  _____

  _____
- ❑ Maternal SSA+ autoantibodies (Lupus, Sjogren's Syndrome)

  Please include labs if possible
- ❑ Exposure to teratogen:

  _____
- ❑ Monochorionic twinning
- ❑ Other: _____

  _____

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

Please FAX Request, Demographics, copy of an insurance card and any relevant clinicals to:

Phone: 650-721-2121 Fax: 650-497-8422

Choose One Option

❑ **Fetal Echo Complete** 76825, 76827, 93325
Consultation Code 99241-99245 **(both required)**

OR

❑ **Fetal Echo Limited** 76826, 76828, 99325
Consultation Code 99241-99245 **(both required)**

Choose One Option

❑ **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.

OR

❑ **Consultation (one visit)**

_____ With fetal echocardiogram
_____ Without fetal echocardiogram

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

Referring Physician Contact Information:

_____

_____

_____

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