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

Medical Record Number

Patient Name

ORDER • FETAL ECHOCARDIOGRAM

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:_____

Please specify the priority of your request:

**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:

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

☐ 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:

_____
_____
_____

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