Seattle Children's
HOSPITAL · RESEARCH · FOUNDATION

Maternal Fetal Intervention & Surgery Appointment Request

Please fax to: 206-985-3274. Scheduling phone: 206-987-4137

Referral Date: _____ **Interpreter needed?** □ **No** □ **Yes Language** _____

Patient Name: _____ **DOB:** _____ **Due Date:** _____

Patient Phone: _____ **Alternate Phone:** _____

Referral reason/ Dx: _____

Desired appointment timeframe: □ **next day** □ **this week** □ **next week** □ **Other:** _____

Name of Referring Provider: _____ **Practice name:** _____

Referring Provider Phone: _____ **Fax:** _____

Primary OB (if not referring**):** _____ **Practice name:** _____

Primary Provider Phone: _____ **Fax:** _____

□ **Complex Monochorionic Multiples: Twins:** □ **Mo/Di** □ **Monoamniotic Triplets:** □**Di/Tri** □ **Mo/Tri**

□ **Twin to Twin Transfusion Syndrome (TTTS): Stage:** □**0/early** □**1** □**2** □**3** □**4**

□ **Twin Anemia Polycythemia Sequence (TAPS)**

□ **Selective Intra-Uterine Growth Restriction (SIUGR) or** □ **Placental Share concern**

□ **Discordant Anomalies:** □ **Twin A** □**Twin B Concern:** _____

□ **TRAP sequence**

□ **Amniotic Bands**

□ **Bladder Outlet Obstruction** □ **Male fetus** □ **Female fetus**

□ **Chest Mass:** □ **CPAM** □ **Chylothorax** □ **Pulmonary Sequestration** □ **Other:** _____

□ **Fetal Anemia Due to:** □ **Rh Iso-immunization** □ **Other:** _____

□ **Myelomeningocele**

□ **Other or Unknown:** _____

Please include with referral:

- Patient demographics + insurance information
- Prenatal panel (Blood type/screen, HIV, Syphilis, Hepatitis B, Rubella) + Any other pertinent lab results
- Ultrasound reports + MFM Consult notes + Prenatal history
- Genetic counseling notes, pedigree, and test results (if applicable)