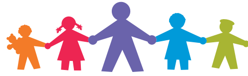

UCSF Benioff Children's Hospital
San Francisco

Request for Fetal Echocardiogram

Fetal Cardiovascular Program
Anita Moon-Grady, MD
Michael Brook, MD
Mark Cocalis, MD
Shabnam Peyvandi, MD
Hythem Nawaytou, MBBCH
Norman Silverman, MD

Phone: (415) 353-1887
Fax: (415) 502-0660
www.fetalheart.org

This form is for cardiac/echo referral only. Please send completed form along with a copy of the insurance card, authorization, and clinical documentation by fax ***(415) 502-0660*** *or email* ***fetalheart@ucsf.edu****.*

For additional Fetal Treatment services please contact the Fetal Treatment Center ***1-800-RX-FETUS (1-800-793-3887).***

Date of Referral ____/____/______
mm/dd/yyyy

Patient Name ____________ ____________
Last First

Date of Birth ____/____/______
mm/dd/yyyy

Patient Contact Info

Address ______________________

______________ ______ ________
City State Zip Code

Home ( ) – Work ( ) –

Mobile ( ) –

Kaiser MR# ____________

Number of Fetuses

☐ Singleton ☐ Twin ☐ Other multiple

Indication for Referral

☐ Increased NT (_____ mm) • O35.8XX0

☐ Family History • O35.2XX0
including patient • O99.419, Q24.9

☐ Diabetes (Type ______________) • O24.919

☐ Maternal SSA/SSB • O35.8XX0

☐ Fetal Arrhythmia • O76

☐ Known Chromosome Abnormality • O35.1XX0

☐ ART/IVF ____________ • 135.8XX0

☐ Other (Specify ________________) • O35.8XX0

Additional Fetal Treatment Indications*

☐ Twin Twin Transfusion Syndrome • O30.039, O43.029

☐ Suspected Abnormality of the Heart • O35.8XX0

☐ Other Abnormalities (Specify ______________)

** If your patient needs additional Fetal Treatment services contact the Fetal Treatment Center at 1-800-RX-FETUS to coordinate the fetal echo and other appointments.*

Obstetrical History

G ____ P ____ TAB ____ SAB ____ IUFD ____

Gestational Age Today ____ weeks ____ days

LMP ____/____/______ EDC ____/____/______
mm/dd/yyyy mm/dd/yyyy

Diagnostic Tests Done

Check all that apply

☐ None ☐ Amnio ☐ CVS ☐ NIPT ☐ Other

Results ______________________

Primary OB

Name ____________ ____________
Last First

Phone ( ) – Fax ( ) –

MFM / Perinatologist

Name ____________ ____________
Last First

Phone ( ) – Fax ( ) –

Submitting Office Contact

Name ____________ ____________
Last First

Phone ( ) – Email ____________

Insurance Preauthorization

If your patient requires insurance preauthorization, please fax or send the confirmation to us prior to the appointment date.

Fetal Echo & Consultation Codes:
76825, 76827, 76820, 93325, 99244

UCSF Staff Only — Scheduling Triage

EGA	☐ 13-14	☐ 18-24	☐ other
Location	☐ FTC	☐ PDC	☐ either
Duration	☐ 1	☐ 1.5	☐ other