

**CHLA-USC-IMFH FETAL THERAPY PROGRAM AT HOLLYWOOD PRESBYTERIAN
HOSPITAL
LOWER OBSTRUCTIVE UROPATHY REFERRAL FORM**

DATE _____

PATIENT _____ AGE _____ Maternal Weight _____ Twins _____

PHYSICIAN _____ LMP _____ EDC _____ GA _____

PHYSICIAN PHONE NO. _____ FAX _____

PHYSICIAN ADDRESS _____

CITY/STATE _____ INSURANCE CO. _____

REPEAT VESICOCENTESIS IN 48 HOURS ONLY IF THE VALUES ON THE FIRST VESICO ARE NOT IN THE RANGES LISTED.

IF NORMAL ON THE FIRST VESICOCENTESIS THE PATIENT CAN BE SCHEDULED FOR EVALUATION FOR THERAPY

	VESICO # 1 DATE _____	VESICO # 2 DATE _____
Sodium (Na) < 100		
Chloride (Cl) < 90		
Osmolality (Osm) < 210		
Calcium (Ca++) < 8		
Beta2 < 10		
Protein < 20		

AMNIOTIC FLUID VOLUME Maximum Vertical Pocket _____ cm AFI _____ cm

BLADDER DIAMETER _____ x _____ x _____ cm

KEYHOLE SIGN _____ No ___ Yes ASCITES _____ No ___ Yes

ULTRASOUND DATE _____	RIGHT KIDNEY	LEFT KIDNEY
RENAL PELVIS	_____ mm	_____ mm
RENAL PARENCHYMA	_____ Normal _____ Echogenic	_____ Normal _____ Echogenic
CYSTIC DYSPLASIA	_____ No _____ Yes	_____ No _____ Yes

PLEASE FAX REFERRAL FORM TO: (323) 361-6099

Insurance authorization will be coordinated by Terri Maitino R.N., who may be contacted by phone at: (323) 361-6074, or by Email at: Tmaitino@chla.usc.edu

DATE REC'D _____	DIAGNOSIS _____
RECOMMENDATION _____	FOLLOWUP _____