CHOC Children's Specialists

Division of Cardiology Fetal Evaluation Referral Form

Patient Information

Does the patient live with someone other than the legal guardian? ☐ No ☐ Yes, relationship_____

Patient Name: _____ Date of Birth: _____ / _____ / _____

Parent/Guardian: _____ Parent Phone: _____

Insurance: _____ Parent Cell: _____

1. Is this an **emergent** Cardiology referral? ☐ No ☐ Yes **If yes, requires a phone call from an MD/ PA/ NP with clinical information to (714) 509-7285**
2. Please designate from the following list:
   - ☐ Suspected cardiac abnormality on obstetric ultrasound
   - ☐ Pre-gestational DM or DM identified in the first trimester
   - ☐ Phenylketonuria
   - ☐ Lupus or Sjogrens
   - ☐ Medication/Teratogen exposure
   - ☐ Maternal Infection
   - ☐ Assisted Reproductive Technology
   - ☐ Family history of structural cardiac disease (maternal, paternal, sibling, second degree relative)
   - ☐ First-or second-degree relative with genetic disorder associated with cardiac disease
   - ☐ Fetal rhythm abnormality
   - ☐ Known or suspected chromosomal/genetic abnormality
   - ☐ Abnormal NT measurement
   - ☐ Abnormality of umbilical cord, placenta, or intra-abdominal venous anatomy
   - ☐ Monochorionic twin gestation
   - ☐ Hydrops fetalis
   - ☐ Other _____

To expedite appointment scheduling, please provide the following by FAX (714) 509-8691:

- ☐ **This completed form**
- ☐ **Medical records related to the chief complaint**
- ☐ **Pertinent laboratory or radiology results**
- ☐ **Authorization including all of the following CPT codes:**
  - **Fetal Cardiology Consultation and Echocardiogram: 99245, 93325, 76825, 76827**

Referring Provider Name: _____ Phone: _____ Fax:_____

Provider Address: _____City: _____Zip: _____

Provider Signature: _____ Date:_____ Time: _____