



Fetal Cardiology Program

Office: 434-24-FETAL

Fax: 434-924-9077

Physician Direct Referral: 800-552-3723

Email: pac2z@virginia.edu or swh5w@virginia.edu

Referring Physician:

FETAL ECHOCARDIOGRAM REFERRAL FORM

Patient Name (First) (Middle) (Last)		Birth date	UVA MR# (if applicable)
Address		E-mail address	
Home Phone	Work Phone		Cell Phone
Insurance	Subscriber		
Group #	Policy #		

Type of Referral: Fetal Echo & Consult

Reason for Referral:

- | | |
|---|---|
| <input type="checkbox"/> Abnormal Ultrasound
Describe: | <input type="checkbox"/> Maternal Diabetes |
| <input type="checkbox"/> Abnormal Fetal Heart Rhythm | <input type="checkbox"/> Medication / Drug Exposure |
| <input type="checkbox"/> Advanced Maternal Age | <input type="checkbox"/> Mother OR Father (circle one) of fetus with known congenital heart disease |
| <input type="checkbox"/> Fetal congenital anomalies or chromosomal problems | <input type="checkbox"/> Prior child or family history of congenital anomaly |
| <input type="checkbox"/> Inflammatory Disease such as SLE | <input type="checkbox"/> Suspected fetal cardiac anomaly |
| <input type="checkbox"/> Other: | |

Pregnancy History:

Pregnancies: Gravida Para Living

Gestational Age:

LMP EDD

Prior Fetal Echocardiograms:

Yes No Performed by: Date:

***** Please fax ALL prior ultrasounds for comparison to the requested exam *****

Date Referred:	Appointment Date:	at	am/pm
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