Request for Fetal Echocardiogram

UCSF Benioff Children's Hospitals

Fax Oakland referrals to 510-985-2202.

Preferred location: ☐ Brentwood ☐ Berkeley ☐ Fairfield ☐ Oakland ☐ Walnut Creek ☐ Next available, any location ☐ Other_____ ☐ URGENT

Fax San Francisco referrals to 415-502-0660.

Preferred location: ☐ Fremont ☐ Greenbrae ☐ Modesto ☐ Monterey ☐ San Francisco ☐ San Mateo ☐ Stockton ☐ Next available, any location ☐ Other_____ ☐ URGENT

*This form is for Fetal Echo referral only. Please send completed form along with a copy of the insurance card, authorization and clinical documentation by to the appropriate fax number listed above 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 Last Name:

Patient First Name:

DOB (mm/dd/yyyy):

Patient Contact Info

Address:

City: **State:** **Zip:**

Home Phone:

Cell Phone:

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 (mm/dd/yyyy): EDC ((mm/dd/yyyy):

Diagnostic Tests Done (Check all that apply)

☐ None ☐ Amnio ☐ CVS ☐ NIPT ☐ Other

Results:

Primary OB

Last Name: First:

Phone: Fax:

MFM / Perinatologist

Last Name: First:

Phone: Fax:

Submitting Office Contact

Last Name: 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