Request for Fetal Echocardiogram

UCSF Benioff Children's Hospitals

Fax Oakland referrals to (510) 985-2202.

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

Fax San Francisco referrals to (415) 353-8675.

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 to the appropriate fax number listed above or via email to **fetalheart@ucsf.edu**.*

*For additional fetal treatment services, please contact the Fetal Treatment Center **(800) RX-FETUS (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, O28.3

☐ Family History • 035.2XX0
Including Patient • 099.419, Q24.9

☐ Diabetes (Type _____) • 024.919

☐ Maternal SSA/SSB • 036.1990

☐ Fetal Arrhythmia • 036.8390

☐ Known Chromosome Abnormality • 035.1XX0

☐ ART/IVF _____ • 035.9XX0, 009.819

☐ Other (Specify _____) • 035.8XX0

Additional Fetal Treatment Indications*

☐ Twin-Twin Transfusion Syndrome • 035.8XX0, 043.029, O36.8290

☐ Suspected Abnormality of the Heart • 035.8XX0

☐ Other Abnormalities (Specify _____)

**If your patient needs additional fetal treatment services, contact the Fetal Treatment Center at (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 Name _____

Phone_____Fax_____

MFM/Perinatologist

Last Name_____First Name _____

Phone_____Fax_____

Submitting Office Contact

Last Name_____First Name _____

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 and 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