Driscoll Children's Hospital

Fetal Cardiology Referral Form

Please attach a demographic sheet or the referral cannot be processed.

Referring Clinic: _____ Phone: _____ Fax: _____

Referring Provider: _____ Practice Name: _____

Contact Number: _____ Fax: _____

Patient Name: _____

DOB: _____ EDD: _____ GA at Referral: _____

Gravida/Para: _____ Multiple Gestation: ☐ Yes ☐ No

Insurance: _____ ID Number: _____

REASON FOR REFERRAL

Maternal Indications *(Select all that apply):*

- ☐ Assisted reproductive technology (IVF/ICSI) pregnancy
- ☐ Autoimmune disease (e.g., SLE, Sjögren's) with SSA/SSB antibodies
- ☐ First-degree relative with congenital heart disease
- ☐ Gestational diabetes diagnosed in 1st or early 2nd trimester
- ☐ Maternal congenital heart disease
- ☐ Maternal infection with cardiac risk (e.g., rubella, CMV, parvovirus, coxsackie, COVID-19 in early pregnancy)
- ☐ Phenylketonuria (poorly controlled)
- ☐ Poorly controlled thyroid disease in pregnancy
- ☐ Pre-gestational diabetes (Type 1 or Type 2)
- ☐ Teratogen exposure (e.g., lithium, SSRI, retinoic acid, anticonvulsants, alcohol, NSAIDs in 3rd trimester)

Fetal Indications *(Select all that apply):*

- ☐ Abnormal cardiac views on obstetric ultrasound (4-chamber, outflow tracts, 3VV)
- ☐ Abnormal umbilical artery or ductus venosus Doppler
- ☐ Chromosomal abnormality (e.g., Trisomy 21, 18, 13, Turner syndrome, microdeletions)
- ☐ Fetal arrhythmia (tachycardia, bradycardia, irregular rhythm)
- ☐ Hydrops fetalis or abnormal fluid collections
- ☐ Increased nuchal translucency (≥3.0 mm) or cystic hygroma
- ☐ Intrauterine growth restriction (IUGR)
- ☐ Monochorionic twin pregnancy
- ☐ Non-cardiac malformation
- ☐ Persistent right umbilical vein
- ☐ Suspected structural heart defect
- ☐ Twin-to-twin transfusion syndrome (TTTS)

Family History/Genetic Indications *(Select all that apply):*

- ☐ Parent or sibling with CHD
- ☐ Known genetic syndrome with cardiac involvement

ADDITIONAL NOTES/PERTINENT HISTORY

REQUESTED TIMEFRAME FOR EXAM

- ☐ Routine (within 2–4 weeks)
- ☐ Expedited (within 1 week)
- ☐ Urgent (within 48 hours)

Please call clinic if Expedited or Urgent so we can get an appointment scheduled.

Referring Provider Signature: _____ Date: _____

LOCATIONS

- ☐ **Corpus Christi/Victoria -** Phone: (361) 694-5086 or (800) 242-0008 | Fax: (361) 808-2196
- ☐ **El Paso -** Phone: (915) 275-1510 | Fax: (915) 745-1634
- ☐ **McAllen/Rio Grande Valley -** Phone: (956) 688-1300 | Fax: (956) 683-9160
- ☐ **Laredo -** Phone: (956) 794-8444 | Fax: (956) 712-3769
- ☐ **San Antonio -** Phone: (210) 236-6833 | Fax: (210) 417-4552