Cincinnati Children's Hospital Medical Center

3333 Burnet Ave., MLC 9014
Cincinnati, OH 45229-3039
Forms: www.cincinnatichildrens.org/consults

FETAL ECHO and CONSULT ORDER FORM

FAX form to 513-803-1111

(After faxing form, encourage the patient to call for appointment.)

Appointments: 513-636-4432, option #1
Questions: 513-636-9931

PATIENT INFORMATION

Patient's Name _____CCHMC MR#_____

Date of Birth _____ Home Phone _____ Alt Phone _____

PREGNANCY INFORMATION

Date of request: _____

Number of fetuses:_____ EDC:_____/_____/_____

Specific questions to be answered:

1. _____

2. _____

Pregnancy complications:_____

_____

REASON FOR TESTING

Please check one:

- ☐ Ascites (no heart problem)
- ☐ Congenital Cystic Adenomatoid Malformation (CCAM)
- ☐ Congenital Diaphragmatic Hernia (CDH)
- ☐ Pleural Effusion (no heart problem)
- ☐ R/O Heart Defect - Non-cardiac anomaly
- ☐ Suspected Cardiac Defect (CHD)
- ☐ Sacrococcygeal Teratoma (SCT)
- ☐ Twin Reversed Arterial Perfusion (TRAP)
- ☐ TTTS (Twin-Twin Transfusion Syndrome)
- ☐ Other _____

PRIORITY: ☐ Routine (next available) ☐ Specific timeframe_____ ☐ Urgent (within ___ days)

REQUESTING PRACTITIONER / GROUP

Office Name _____ Practitioner Name _____

Office Address _____ Telephone _____

_____ Fax_____

Signature / Credentials of ordering Practitioner _____ Date _____