FETAL ECHOCARDIOGRAPHY REQUISITION / FETAL CARDIOLOGY REFERRAL FORM

DATE:______________________________

Patient Details:

Name:______________________________

Date of Birth: ______________________________

OHIP Number: ______________________________

Address: ______________________________

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Phone: ______________________________

Email: ______________________________

Gestational age (weeks): ______________

Estimated due date: ______________

G P SAB TAB

Reason for Referral (check all that apply):

☐ Inability to clear fetal heart x 2 attempts

☐ Suspected fetal cardiac finding (anomaly, rhythm, effusion)

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☐ Family history of heart disease (i.e., first degree relative, prior fetus/child)

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☐ Maternal disease (i.e., autoimmune anti-bodies, diabetes), pregnancy condition (monochorionic), teratogenic exposure

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☐ Abnormal 1st trimester screen (i.e., NT > 3.5 mm)

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☐ Extracardiac or chromosomal anomaly (please specify)

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☐ Other: ______________________________

Referring Physician/Midwife:

Name: ______________________________

Signature: ______________________________

Address: ______________________________

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Phone: ______________________________

Fax: ______________________________

Email: ______________________________

Other Providers:

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Please mark and attach the following supporting documents to the referral:

Antenatal records ☐

Ultrasound reports ☐

Bloodwork (i.e., antibody titers) ☐

Genetic results ☐

The Hospital for Sick Children
Labatt Family Heart Centre

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