USF HEALTH FETAL CARE CENTER OF TAMPA BA

OWER OBSTRUCTIVE UROPA

Please fax this form, sono report and prenatals

TODAY'S DATE_____ /_____ /_____

Patient_____ Age_____ Mater

Physician_____LMP_____ EDD_____ EGA

Physician Phone No._____

Physician Address_____

City/State_____Insurance Co_____

Ultrasound Date	Right Kidney	
Renal Pelvis	mm	
Renal Parenchyma	☐ Normal ☐ Echogenic	☐
Cystic Dysplasia	☐ No ☐ Yes	☐

AMNIOTIC FLUID VOLUME Maximum Vertical Pocket _____cm

BLADDER DIAMETER _____x _____x ____

KEYHOLE SIGN _____No _____Yes ASCI

1. If a serum screen or non-invasive prenatal testing has been performed is the

   Down's Syndrome? _____Yes _____No Neural tube

   Others? _____Yes _____No

   Details_____

2. Has the patient undergone any diagnostic genetic procedures? _____A

3. If a diagnostic genetic procedure has been performed, please provide: Date

   Results_____

If you have performed a vesicocentesis, please complete.

	Vesico #1 Date	Vesico #2 Date
Sodium (Na) < 100mEq/dl		
Chloride(Cl) < 90mEq/dl		
Osmolality(Osm) < 210mOsm/L		
Calcium(Ca++) < 8mEq/dl		
Beta2 < 10mg/l		
Protein < 20mg/dl		

OFFICE
Date Re
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