



**THE MARYLAND
WOMEN'S CENTER**
DEPARTMENT OF OBSTETRICS, GYNECOLOGY
AND REPRODUCTIVE SCIENCES

Center for Advanced Fetal Care
22 South Greene Street, 7th Floor.
Baltimore, Maryland 21201-1703
410 328-3865 / Fax: 410 328-6368

Patient Information
Twin-Twin Transfusion Syndrome

Date: _____ Name: _____ Date of birth: _____
Gestational age: _____ (Week / day)

Referring Physician / Hospital	<div style="border: 1px solid black; height: 40px; width: 100%;"></div>		
	Phone: _____	Fax: _____	
Recipient	Is characterized by polyhydramnios with a maximal vertical amniotic fluid pocket of greater than 8 cm, a distended urinary bladder and possibly signs of hydrops		
Donor	Is characterized by anhydramnios (stuck twin) and an empty, or near empty bladder.		
Placenta	Anterior <input type="checkbox"/>	Posterior <input type="checkbox"/>	Fundus <input type="checkbox"/>
	Lateral <input type="checkbox"/>	Left <input type="checkbox"/>	Right <input type="checkbox"/>
Amniotic fluid	Deepest vertical pocket	Recipient _____ mm	Donor _____ mm
Bladder filling	Recipient Dilated / tensely filled <input type="checkbox"/>	Normal <input type="checkbox"/>	
	Donor Empty / not visualized <input type="checkbox"/>	Normal <input type="checkbox"/>	
Umbilical artery Doppler	Pulsatility Index	Recipient _____	Donor _____
	End-diastolic flow	_____	_____
Cervix	Length on sonogram _____ mm	funneling <input type="checkbox"/>	yes <input type="checkbox"/> no <input type="checkbox"/>
Labor	Preterm labor ? <input type="checkbox"/>	yes <input type="checkbox"/>	no <input type="checkbox"/>
Amniocentesis	Did you have any / repeated Amniocentesis / reduction	<input type="checkbox"/>	yes <input type="checkbox"/> no <input type="checkbox"/>

Please fax the above information to **410 328 6368**. We will contact you shortly thereafter