# Fetal Cardiology Second Opinion Request page 1 of 2

Boston Children's Hospital
Fetal Care & Surgery Center
bostonchildrens.org/fcsc
617-355-6512 | *fax* 617-730-0124
MFCCReferrals@childrens.harvard.edu

The Fetal Care and Surgery Center is committed to providing the best care possible. Please fill out this form and return it with any requested clinical records so that our cardiac specialists may use the information to develop your treatment plan.

Be sure to **fill out the form completely** to avoid any delays in the review process.

## Patient information

First name: _____

Last name: _____

Date of birth: _____ Gender: ❍ Male ❍ Female ❍ Other: _____

Address: _____

City: _____

State/Province/Region: _____

Zip/Postal code: _____ Country: _____

Preferred phone: _____
❍ Cell ❍ Home ❍ Office ❍ Other

Alternate phone: _____
❍ Cell ❍ Home ❍ Office ❍ Other

Email: _____

Race(s)/Ethnicity: _____ Spiritual affiliation: _____

Preferred language: _____ Interpreter needed? ❍ Yes ❍ No

## Spouse/Partner information

First name: _____

Last name: _____

Date of birth: _____ Relation to patient: _____

Gender: ❍ Male ❍ Female ❍ Other: _____

Occupation: _____

Address (if different than patient): _____

_____

City: _____ State/Province/Region: _____

Zip/Postal code: _____ Country: _____

Preferred phone: _____
❍ Cell ❍ Home ❍ Office ❍ Other

Alternate phone: _____
❍ Cell ❍ Home ❍ Office ❍ Other

Email: _____

## How did you hear about us? Select all that apply:

❏ Facebook group (name of group): _____
❏ Recommendation from another patient family
❏ Physician referral
❏ Boston Children's website or internet search
❏ Agency, organization or foundation, name: _____
❏ Other: _____

## Patient provider information

**Local OB:** _____

Address: _____

City: _____

State/Province/Region: _____

Zip/Postal code: _____ Country: _____

Phone: _____ Fax: _____

Email: _____

**Primary Care Physician (PCP):** _____

Address: _____

City: _____

State/Province/Region: _____

Zip/Postal code: _____ Country: _____

Phone: _____ Fax: _____

Email: _____

## Patient medical history

Due date: _____

Height: _____ Weight: _____

Is your pregnancy: ❍ Single ❍ Twins ❍ Triplets ❍ Higher multiples?

_____

Total number of pregnancies: _____ Number of living children: ___

**Names and ages of children**

Child #1 name: _____ Age: _____

Child #2 name: _____ Age: _____

Child #3 name: _____ Age: _____

Child #4 name: _____ Age: _____

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Have you had an amniocentesis or other genetic testing? ❍ Yes ❍ No

Have you had any complications with this pregnancy? ❍ Yes ❍ No

Is there a family history of congenital heart disease? ❍ Yes ❍ No

Do you have any medical conditions? ❍ Yes ❍ No

Have you ever had surgery or been hospitalized? ❍ Yes ❍ No

What is your occupation? _____

What is your marital status? _____

Current medications: _____

_____

_____

_____

_____

## What medical questions would you like our team to help answer for you?

_____

_____

_____

_____

_____

_____

_____

_____

_____

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_____

_____

Are you interested in relocating to Boston for delivery and your baby's heart surgery?

❍ Yes ❍ No ❍ Need more information first

## Type of insurance/Payment method

❑ International self-pay ❑ Health insurance ❑ Embassy

Other: _____

## Guarantor information

❑ Check here if you are your Guarantor.
If so, you do not need to complete the Guarantor section below.

First name: _____

Last name: _____

Date of birth: _____ Gender: ❍ Male ❍ Female ❍ Other: _____

Relationship to patient: _____

City: _____

State/Province/Region: _____

Zip/Postal code: _____ Country: _____

## Insurance information

**Primary insurance:** _____

Type: ❍ HMO ❍ PPO ❍ Medicaid ❍ Other

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Subscriber name: _____

Date of birth: _____ Relationship to patient: _____

Subscriber ID #: _____

Group #: _____

Employer: _____

Employer address: _____

City: _____ State: _____ Zip: _____

Employer phone: _____


### Insurance cards

Make copies of both the front and back of your health insurance card(s) and send them, along with the completed form, to your Case Coordinator.