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# Referral for fetal therapy

Date**:**……………… Referring Physician /Center ……………………………….………… ….

Email:……………………………….…. ……………………………………………………….

Phone:………………………… …………………Fax………...………… ……………………

Patient´s name…………………………………………………Phone:…………………………

Email:…………………………….. ……………………….English speaking? □ Yes □ No

Date of birth:………………….Gestation EDD:……………Parity:…….......Weight/BMI……

□ Singleton □ Twins □ Triplets

□ Fetal anemia □ TTS □ SIUGR □ Other ( TAPS, TRAP, Malformation)

Other important information:

**For referral for fetal therapy to Karolinska Stockholm or Rigshospitalet Copenhagen, fill in this form, call AND fax or email to the numbers below. We will contact you on the same day. Please call instead of faxing on weekends and holidays.**

**Center for Fetal Medicine and Fetal Therapy, Karolinska, Stockholm**

**Phone +46 8 12370687**

**Fax +46 8 12394309**

**Email: fetaltherapy.karolinska@regionstockholm.se**