



Center for Fetal Diagnosis and Therapy

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**CHECKLIST PRELIMINARY EVALUATION
FOR EVENTUAL FETAL SURGERY IN ZURICH**

Please print, fill-out, then scan and send to one of the following persons:

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MATERNAL EVALUATION

Family Name:

First Name:

Date of Birth (min. 18 years):

Phone home:

Phone work:

Phone mobile:

Email:

Home address:

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Marital status:

Profession/education:

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Insurance coverage for treatment abroad:

Number of pregnancies:

Number of births:

Gestational age today (enter date): = +

Singleton/twins/triplets:

Prematurity (preterm births / short cervix <20mm, cervical banding):

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Pregnancy-associated conditions (gestational diabetes, eclampsia, maternal-fetal Rhesus-Isoimmunisation, Kell, alloimmun Thrombocytopenia):

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Uterus-associated conditions (myoma, malformations, hysterotomy in active uterine segments):

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Position of placenta (anterior / posterior / previa):

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Insertion of umbilical cord:

Amount of amniotic fluid (normal / polyhydramnios / oligohydramnios):

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Previous surgeries (problems?):

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Previous general anesthetics (problems?):

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Serious illness (HIV, hepatitis, hypertension, diabetes, cardiac disease, lung disease, brain disease, kidney disease):

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Body weight, body length, Body Mass Index:



Psychiatric disorders:

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Social problems:

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Drugs prescribed by physician:

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Smoking:

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Alcohol:

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Drug consumption:

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FETAL EVALUATION

Myelomeningocele / Myeloschisis (upper level / lower level):

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Gibbus / kyphus / scoliosis / other vertebral malformation:

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Arnold Chiari Malformation II:

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Other cerebral conditions:

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Ventricular size:

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Leg movements (hips, knees, ankles, toes):

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Talipes / clubfeet (other deformities):

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Amniocentesis (karyotype):

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