Department of Congenital Heart Disease

**Non-Urgent Referral Form**

|  |
| --- |
| **All GP referrals must be submitted through the eRS portal** All other referrers please ensure all sections are completed or it will be returned to the senderPlease return completed forms to: **gst-tr.ELCHPaedCardioReferrals@nhs.net** |

Patient Details

|  |  |
| --- | --- |
| Patient Name |  |
| NHS Number |  | Date of Birth |  |
| Patient address & Post Code |  |
| Phone Numbers |  | Previously treated at GSTT: |  |

Referrer’s details

|  |  |
| --- | --- |
| Referral date & time |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Name & grade of person completing form |  | nhs.net email |  |
| Contact Number & Bleep details for person completing the form  |  |
| Referring Consultant  |  |
| Address of hospital |  |

Clinical Details

|  |  |
| --- | --- |
| Cardiac Diagnosis (if known) |  |
| Reason for referral |  |
| Clinical History, Examination,Observations (including weight) InvestigationsFamily history |  |
| Medication – please document all medication |  |
| Safeguarding Concerns (if yes provide details) |  |