Evelina London Fetal Cardiology
Department of Congenital Heart Disease
Ground Floor, South Wing
St Thomas' Hospital
Westminster Bridge Road
London
SE1 7EH

Direct Telephone Numbers: 020 7188 2308
020 7188 9201

Email: gst-tr.fetalcardiologygstt@nhs.net

REFERRAL FORM FOR A FETAL CARDIOLOGY SCAN

Referral forms must be legible and fully completed for the referral to be accepted. This will cause a delay to providing the necessary care to your patient. Please complete and email to gst-tr.fetalcardiologygstt@nhs.net

Date of Referral:
NHS No.:
Patient name:
Address:

Postcode:
Tel No.:
D.O.B:
Email address:
B.M.I:
E.D.D:
Gestation:
Does this patient require an interpreter? YES/NO
Language……

Referring hospital information
Referring department:
Patient's obstetrician:

GP name:
Address:
Postcode:

Hospital contact:
Name:
Tel No:
Fax No:
Nhs.net email:

Reason	Details
1. Suspected congenital heart disease in this baby **(If yes, please call through to office to alert staff and attach scan report)**	Details:
2. Previous pregnancy affected by congenital heart disease (live birth, TOP, neonatal death, infant death)	Diagnosis:
a. Pregnant woman herself or father of fetus has CHD	Diagnosis:
b. Cardiomyopathy in pregnant mother, father of fetus or previous child If so type of cardiomyopathy	Diagnosis:
3. Fetal Arrhythmia? (P**lease attach scan report)**	Slow Fast Irregular
4. Increased nuchal translucency	Nuchal measurement:
5. Other abnormality in this baby	
6. Fetal Hydrops	
7. Monochorionic twins	
8. Drug exposure – medication (e.g. anticonvulsants in early pregnancy	Which drugs
9. Maternal diabetes	
10. Maternal anti-Ro/anti-La antibodies (Lupus)	

Additional information……

Has patient attended this department before?
Yes / No Please specify if under a different name……