Evelina London Fetal Cardiology Direct Telephone Numbers: 020 7188 2308





Department of Congenital Heart Disease 020 7188 9201

Ground Floor, South Wing

St Thomas’ Hospital Email: gst-tr.fetalcardiologygstt@nhs.net

Westminster Bridge Road

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SE1 7EH

**REFERRAL FORM FOR A FETAL CARDIOLOGY SCAN**

***Referral forms must be legible and fully complete. Please ensure the 12 week dating scan, 20 week anatomy scan and the maternity booking document are attached.***

***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 the patient require an interpreter? YES/NOLanguage………………………………………Twin pregnancy (specify what type)……………………………First trimester scan date: Anatomy scan date:  | **Referring hospital information** Referring department: Patient’s obstetrician: GP name: Address: Postcode:  **Hospital contact:** Name: Tel No: Fax No: NHS.net email: Is patient known to Safeguarding? Yes/No |

|  |  |
| --- | --- |
| **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, termination of pregnancy, neonatal death, infant death)  | Diagnosis:   |
| 3. Pregnant patient or father of the baby with congenital heart disease1. Pregnant woman has congenital heart disease
2. Father of the fetus has congenital heart disease
 | Diagnosis:   |
| 4. Confirmed cardiomyopathy in pregnant woman, father of fetus or previous child/fetus If so type of cardiomyopathy  | Diagnosis:  |
| 5. Fetal Arrhythmia?  **(Please attach scan report)**  | Slow - Fast - Irregular - |
| 6. Increased nuchal translucency  | Nuchal measurement:   |
| 7. Other abnormality in this baby  |   |
| 8. Fetal Hydrops  |   |
| 9. Monochorionic twins  |   |
| 10. Medication exposure | Name of medication:  |
| 11. Maternal condition * Diabetes
* anti-Ro/anti-La antibodies (Lupus/Sjogren’s)
* phenylketonuria
 |   |

**Additional information…………………………………………………………………………………………………………………………**

Has patient attended this department before? Yes / No

Please specify if under a different name………………………………………………………………………………….