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

London

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/NO  Language………………………………………  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 disease   1. 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………………………………………………………………………………….