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 legible, fully completed and include reports for 12 week dating scan, 20 week anomaly scan and the maternity booking document for the referral to be processed and avoid unnecessary delays.***

***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……………………………………… | **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, 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?  (P**lease 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 | Which drugs  |
| 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………………………………………………………………………………….