Department of Congenital Heart Disease

Urgent Referral Form

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| **All Urgent referrals must be discussed with the on-call paediatric cardiology registrar via the hospital switchboard (020 7188 7188) before completing this form**All sections must be completed or it will be returned to the senderOnce discussed and form completed please return it to: **gst-tr.URGENTEvelinaPaedCardReferral@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 of Registrar discussed with |  |

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

Clinical Details

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