**DATE OF REFERRAL:** Click here to enter a date.

**PREGNANCY DETAILS**

**EDD: Gestation:**

**Pregnancy number:**

**BMI:**

**Invasive testing performed?**

**Interpreter required? (Specify Language)**

**Safeguarding issues?**

**PATIENT DETAILS**

**NHS Number:**

**Name:**

**DOB:**

**Address:**

**Post Code:**

**Telephone/Mobile:**

**GP DETAILS**

**GP Name and Address:**

**REFERRING HOSPITAL**

**Referring Hospital:**

**Name of Obstetrician:**

**Name/phone/nhs.net net of screening coordinator:**

**REASON FOR REFERRAL (please tick) – please add as much detail as possible to allow appropriate triage**

|  |  |  |
| --- | --- | --- |
| **Referral reason** | **Tick** | **Please add details** |
| 1. **Urgent referral** for **suspected heart abnormality** in this baby:

(please give details and send scan report)  |  |  |
| 1. Fetal arrhythmia

(please give heart rate) |  |  |
| 1. Family history congenital heart disease

 (screening offered for CHD in parent or sibling of fetus – please give relationship and diagnosis) |  |  |
| 1. NT greater or equal to 3.5mm

(please give NT measurement) |  |  |
| 1. Maternal diabetes
 |  |  |
| 1. Extra cardiac anomaly with cardiac associations or abnormal karyotype

(please give diagnosis) |  |  |
| 1. Exposure to potential teratogen

(please specify) |  |  |
| 1. Monochorionic twins
 |  |  |
| 1. Maternal anti Ro antibodies
 |  |  |
| 1. Other: please give details
 |  |  |