**Fetal Medicine Referral**

The Rotunda Hospital, Parnell Square, Dublin 1

Phone: 01 – 817 1357 Fax: 01 – 872 6572

Email: fetalmed@rotunda.ie



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| **Date of referral**: | **Previously attended: Yes / No** |
| **Name:** | **Date of birth:** |
| **Addressograph:** | **Home tel:** |
| **Mobile no:**  |
| **Referring consultant:** | **Referring consultant contact number:** |
| **Referring unit address:** |
| **Name of GP:** | **Name of GP practice:** |
| **Address:** |
| **Current gestational age:** | **EDD:** | **Blood group:** |
| **Referral for: Tick Box****1. Suspected ultrasound- detected fetal abnormality (specify)** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****2. Multiple pregnancy: monochorionic/chorionicity uncertain/higher- order multiple** **3. Red cell alloimmunization: D / Kell /Other** **Titre\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Paternal genotype\_\_\_\_\_\_\_\_\_\_\_\_\_\_****4. Aneuploidy screening (note – there is a charge for this service)** **5. Invasive testing for familial genetic condition (specify)** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Further information:**  |
| **Interpreting services:**  | **Language required:** |
| **FOR FMU USE ONLY:** |
| **Date Received:** | **Triage Notes:** |
| **Clinic Code:** | **Appointment Date/Time:**  | **Hospital No:**  |

Please fax this referral form along with previous ultrasound reports, details of previous affected pregnancies, relevant family history etc to 01 – 872 6572or email to fetalmed@rotunda.ie