**Fetal Medicine Referral**

The Rotunda Hospital, Parnell Square, Dublin 1

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

Email: [fetalmed@rotunda.ie](mailto:fetalmed@rotunda.ie)



|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **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](mailto:fetalmed@rotunda.ie)