The Leeds Teaching Hospitals NHS
NHS Trust

DEPARTMENT OF FETAL CARDIOLOGY
LEEDS GENERAL INFIRMARY

Telephone: 0113 3925079 Fax: 0113 3925096

Mother's Surname: ……Forenames: ……

Address:……

……

……

Post Code: …… Date of Birth: ……

Telephone No: ……Mobile No:……

GP Name:……

GP Address:……

……

Referring Consultant: …… Referring Hospital: ……

Hospital No.: …… NHS No.:……

Pregnancy No. …… Gestation: …… EDD:……

Reason for referral:……

……

If referral for family history, please provide name & D.O.B. of affected 1st degree relative of the fetus and details of condition: ……

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If referral if for Diabetes please provide HbA1c at conception ……

Other fetal abnormalities: ……

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Details of any previous pregnancies:

……

……

Date and time of Appointment (for office use only): ……

Referral Requested by:
Name: *Date of Referral:*
Job Title: *Contact No.:*
Referrers Signature:

To make an appointment please complete this referral in full and fax to Fetal Cardiology.
For urgent referrals or advice, please call (numbers above).

****** INCOMPLETE REFERRALS WILL BE RETURNED AND MAY RESULT IN SIGNIFICANT DELAY IN SEEING THE PATIENT******