**GSTT CLINICAL GENETICS: WARD ROUND REFERRAL**

ALL FIELDS ARE REQUIRED

* For any urgent queries please contact the on-call Clinical Genetics SpR **via switchboard**
* For inpatients needing urgent review, please email this form to GeneticsWardReferrals@gstt.nhs.uk
	+ Subject: Ward Round Referral: FORENAME SURNAME
* We will contact your team to agree a date for ward round review
* For routine outpatient referrals send this form (or referral letter) to: gst-tr.geneticsreferrals@nhs.net
* General enquiries can be sent to the on-call SpR via email: GeneticsRegistrars@gstt.nhs.uk

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| **Identifying information** *(including parental information for children)* |
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| **Patient** |  |
| Full name: Click here to type | DOB: dd/mm/yyyy |
| Hospital #: Click here to type | NHS #: **000-000-0000** |
| Sex: Choose from dropdown list | Date of referral: dd/mm/yyyy |
| Ethnic background: Click here to type | Age at referral: 0 years 0 months |
|  |  |
| **Parents** |  |
| Mother’s name: Click here to type | Father’s name: Click here to type |
| Mother’s DOB: dd/mm/yyyy  | Father’s DOB: dd/mm/yyyy |
| Mother’s hospital #: Click here to type | Father’s hospital #: Click here to type |
| Mother’s NHS #: 000-000-0000  | Father’s NHS #: 000-000-0000 |

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| **Inpatient information** |
| *Complete this section if your patient needs review for* **inpatient** *diagnostic/management implications.* *For OP referrals, follow the pathway at:* [*https://www.guysandstthomas.nhs.uk/our-services/genetics/referrals*](https://www.guysandstthomas.nhs.uk/our-services/genetics/referrals)

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| Ward: Click here to type | Bed #: Click here to type |
| Organ support: Click here to type | Estimated discharge/transfer date: dd/mm/yyyy |
| Ward Dr bleep: #0000 | Ward nurse phone: #00000 |
| Referrer email: name@gstt.nhs.uk | Consultant in charge email: name@gstt.nhs.uk |
| Language: Click here to type | *(if interpreter needed, ward to book on agreed date)* |
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| --- | --- | --- | --- | --- |
| Monday | Tuesday | Wednesday | Thursday | Friday |
| [ ] AM  | [ ] AM | [ ] AM | [ ] AM | [ ] AM |
| [ ] PM | [ ] PM | [ ] PM | [ ] PM | [ ] PM |

Parental availability on the ward- ideally both *(check box for yes)*: |

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| **Clinical information** |
| *Referral indication, PMHx, FHx, examination findings, investigation results:**Current clinical plan:* |

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| **Genetics information** |
| *Complete the section below if either the patient or their relative has been previously assessed by Clinical Genetics or has a known relevant genetic diagnosis. Repeat for multiple family members.*

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| Relationship to patient: Click here to type |
| Full name: Click here to type | DOB: dd/mm/yyyy |
| Date of assessment: Click here to type | Hospital: Click here to type |
| Diagnosis, clinical details, investigations: Click here to type |

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| **Genetics internal use only** |
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| PRU: Click here to type |
| Dr receiving referral: Click here to type |
| Ward round consultant: Click here to type |
| Agreed ward round date dd/mm/yyyy |
| Plan: Click here to type |

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