

**Referral to Clinical Genetics RAPID ACCESS CLINIC**

- ☐ **First, ring the duty genetic counsellor on 0207 188 1364 or 0207 188 1402**
- ☐ **Complete and email form to: [gst-tr.geneticsreferrals@nhs.net](mailto:gst-tr.geneticsreferrals@nhs.net)**
- ☐ **Attach** relevant reports eg. dating scan, confirmation of diagnosis

**Patient details** (please PRINT – incomplete or illegible forms will delay patient care)

Patient name: Address: Postcode:  DOB: NHS number: PRU number (if known):		Hospital number:   GP phone number:
GP Name: GP Address:		
Patient telephone number(s):		
Patient email:		
<input type="checkbox"/> <b>due to urgency of referral, this patient agrees to be contacted by phone and email</b> <input type="checkbox"/> <b>patient is aware of this referral</b> Referral reason:  Family history: (use patient's own words) Draw family tree:          <div style="display: flex; justify-content: space-between;"> <span>Is the patient/partner <b>pregnant?</b>    <input type="checkbox"/> yes    <input type="checkbox"/> no</span> </div> <div style="display: flex; justify-content: space-between;"> <span><b>LMP:</b></span> <span><b>EDD:</b></span> <span><b>SCAN DATE:</b></span> </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <span>Patient's ethnicity: <b>Other :</b></span> <span>Partner's ethnicity:</span> </div>		

**Referrer details:**

Name and designation:  
Address:

Email:

Phone Number:

Midwife name:  
Midwifery group:

Signature of referrer:  
Print your full name:

Date: