**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](mailto: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](mailto:gst-tr.geneticsreferrals@nhs.net)
* General enquiries can be sent to the on-call SpR via email: [GeneticsRegistrars@gstt.nhs.uk](mailto:GeneticsRegistrars@gstt.nhs.uk)

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| **Identifying information** *(including parental information for children)* |
| |  |  | | --- | --- | | **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 | |
| **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)   |  |  | | --- | --- | | 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)* | | |  |  |  |  |  | | --- | --- | --- | --- | --- | | 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)*: | | |
| **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.*   |  |  | | --- | --- | | 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 | | |
| **Genetics internal use only** |
| |  | | --- | | 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 | |