**Mary A Rutherford, MD FRCR MRCPCH**

Perinatal Imaging

Centre for Developing Brain

Division of Imaging Sciences

**PROFORMA FOR IMAGE REFERRAL**

1st Floor South Wing

St Thomas’s Hospital

SE1 7EH

Tel: 0207 188 9156

**Please email this completed referral to:**

**dulcie.rodrigues@nhs.net, mary.rutherford1@nhs.net and stefanie.chan@nhs.net**

**If this is a very URGENT request requiring same day feedback please send text/What’s App to Mary Rutherford on 07717652661**

**Please ask your PACS team to send the images via bluelight to the PACS team at GUYS and ST THOMAS**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Date:** |  | | **Hospital (imaging centre)** | |  |
| **Consultant/s:** |  | | **Hospital (delivery/ referral back to)** | |  |
|  | | | | | |
| **Baby Details** | | | | | |
| **Name:** |  | | **GA at Birth:** | |  |
| **DOB:** |  | | **PMA at MRI:** | |  |
| **NHS No:** |  | | **Birth Weight:** | |  |
| **Address:** |  | | **Birth OFC:** | |  |
| **Current Weight:** | |  |
| **Current OFC:** | |  |
| **Date of Scan:** | |  |
|  | | | | | |
| **Antenatal Details** | | | | | |
| **Gravida/Para:** |  | | **TOP/Miscarriage** | |  |
| **Serology** |  | | **Scans** | |  |
| **PROM:** |  | | **Fever:** | |  |
| **Haemorrhage:** |  | | **Decreased fetal movements:** | |  |
| **Family History:** |  | | | | |
| **Any other concerns:** |  | | | | |
|  | | | | | |
| **Labour Details** | | | | | |
| **Onset:** |  | | | | |
| **Sepsis Risk Factors:** |  | | | | |
| **Antenatal Steroids:** |  | | | | |
| **Delivery** | | | **Delivery Details** | | |
| **Mode:** |  | |  | | |
| **Indication:** |  | |
| **Resuscitation:** |  | |
| **Cord Blood Gases:** | **Venous:**  **Arterial:** | |
| **Apgar (1, 5, 10mins)** |  | |
| **Placenta Examined:** |  | |
|  | | | | | |
| **Neonatal Course/Complications To Date** | | | | | |
| **Respiratory:** |  | | | | |
| **Cardiac:** |  | | | | |
| **Haematological:** |  | | | | |
| **Blood Glucose:** |  | | | | |
| **Metabolic:** |  | | | | |
| **Infection:** |  | | | | |
| **Gastrointestinal:** |  | | | | |
| **Current medication:** |  | | | | |
| **Current feeding:** |  | | | | |
| **Discharge Date:** |  | **Discharged to:** | | **Home Hospital** | |
|  | | | | | |
| **Neurological Details** | | | | | |
| **Encephalopathy:** |  | | | | |
| **Clinical seizures:** |  | | | | |
| **CFM/EEG:** |  | | | | |
| **Cranial US Findings:** |  | | | | |
| **Current neurological examination:** |  | | | | |
| **Genetics:** |  | | | | |
|  | | | | | |
| **Summary/Any Further Information** | | | | | |
|  | | | | | |

**Please list all emails of individuals who would like a formal report including, where possible, the original hospital where baby was delivered or referred back to.**