SPAH
SCOTTISH PAEDIATRIC AND ADULT HAEMOGLOBINOPATHIES NETWORK

TRANSCRANIAL DOPPLER SCAN REFERRAL FORM

First Name:		**DOB:**	
Last Name:		**CHI/Patient ID:**	
Title:		**Phone No:**	
Address:		**GP details:**	
Post Code:		**Ethnicity:**	

Diagnosis: Please do not refer until diagnosis is known	☐ **HbSS**	☐ **HbS/ß-thal**	☐ **HbSC**	☐ **Other** Please specify
Interpreter required:	☐ **Yes – Language:**			☐ **No**

History of Stroke:	☐ **Yes**	☐ **No**
History of other neurological problems:	☐ **Yes**	☐ **No**
Details:		
Transfusion regime:	☐ **Yes**	☐ **No**
Previous transcranial Doppler scan:	☐ **Yes**	☐ **No**
If yes, date of last TCD Scan: (Please enclose copy of report if available)		
Scan result:	☐ **Normal**	☐ **Abnormal**
	☐ **Conditional**	☐ **Unsatisfactory**
Additional Patient info (e.g. non-verbal/ASD/ADHD)		

Referral Source (Name):	
Referral Centre:	
Referral Centre contact number:	

Please complete and return to the RHC Non-malignant team on:
ggc.rhctcdreferrals@nhs.scot

Please contact centre on 0141 452 4479 if an email confirming receipt has not been received within 5 working days.