


SPA

SCOTTISH PAEDIATRIC AND ADULT HAEMOGLOBINOPATHIES NETWORK

TRANSCRANIAL DOPPLER SCAN REFERRAL FORM

First Name:				Last Name:			
Gender:	☐ M	☐ F	☐ Other	DOB:			
Ethnicity:				CHI / NHS ID:			
Patient Address:							
Post Code:				Phone No:			
Email:							
GP details:							
Interpreter required:	☐ Yes – Language:					☐ No	
Additional Patient info	(e.g. non-verbal/ ASD/ADHD)						
Diagnosis: Please do not refer until diagnosis is known	☐ HbSS ☐ HbS/β-thal		☐ HbSC ☐ Other, please specify				
History of Stroke:	☐ Yes			☐ No			
History of other neurological problems:	☐ Yes			☐ No			
Details:							
Transfusion regime:	☐ Yes ☐ No		Hydroxycarbamide:	☐ Yes ☐ No			
Previous TCD:	☐ Yes ☐ No		Details of Scan	Date:			
Scan result:	☐ Normal	☐ Abnormal	☐ Conditional	☐ Unsatisfactory			
	Details:						
Referral Source (Name):							
Referral Centre:							
Referral Centre contact number:							
Referral Centre contact email:							

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

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

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