NHS SCOTLAND

SPAH
SCOTTISH PAEDIATRIC AND ADULT HAEMOGLOBINOPATHIES NETWORK

TRANSCRANIAL DOPPLER SCAN REFERRAL FORM

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

Referral Source (Name):		
Referral Centre:		
Referral Centre contact number:		
Diagnosis:		
Interpreter required:	☐ **Yes**	☐ **No**
If yes, which language:		

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**

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

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