Ultrasound Diagnostic Services

115 Harley Street, London W1G 6AP

APPOINTMENT : …….……

Tel: 020 7935 2243 / 020 7486 7991
Fax: 020 7935 7558

PATIENT'S NAME: …….

TELEPHONE No: ...……..

ADDRESS: ……

……

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REFERRING DOCTOR: ……..

TELEPHONE No: ...……..

ADDRESS: ……

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EARLY PREGNANCY/DATING SCAN *(5-10 weeks)*	☐	CHORION VILLUS BIOPSY *(11-20 weeks)* OR	☐
EARLY ANOMALY SCREEN/NUCHAL TRANSLUCENCY *(11-13 weeks)*	☐	AMNIOCENTESIS *(15-20 weeks)* OR	☐
COMBINED NUCHAL + BLOOD TEST	☐	CORDOCENTESIS *(20 weeks)*	☐
DOWN'S SCREENING – (BARTS) (mini scan + quadruple blood test)	☐	PELVIC SCAN	☐
FETAL ANOMALY SCAN *(20 weeks)*	☐	OVARIAN CANCER SCREENING (symptom-free patients)	☐
FETAL ANOMALY SCAN + UTERINE DOPPLER	☐	FOLLICLE TRACKING	☐
FETAL WELL-BEING – GROWTH & FETAL DOPPLER *(from 24 weeks)*	☐	LOCATION OF I.U.C.D.	☐

L.M.P: ……. D.O.B: ……. BLOOD GROUP: …….

PLEASE GIVE RELEVANT CLINICAL DETAILS BELOW *(continue overleaf if required)*