HIGH RISK EXTERNAL REFERRAL FORM

COOMBE FETAL MEDICINE
COOMBE WOMEN & INFANTS UNIVERSITY HOSPITAL
CORK STREET
DUBLIN 8
Email highriskus@coombe.ie

Office use only

Please place patient's ID label here

DATE OF REFERRAL _____

From : Midland Regional Hospital, Portlaoise

Please PRINT patient details below.

NAME			
ADDRESS			
DOB		**CONTACT NO.**	
EDD (SCAN)		**GESTATION(WKS)**	

Please detail reason for Ultrasound request.

Referring Consultant details

NAME	
CONTACT NO	

Please email this referral to: highriskus@coombe.ie