EXTERNAL REFERRAL FORM

Ultrasound/ Fetal Medicine Department

Coombe Women & Infants University Hospital

Cork Street, Dublin 8

Tel - +353 1 4085578

Fax - +353 1 4085574

Email – perinatal@coombe.ie

Date of Request -

Patient Details

Name	
Address	
DOB	
Contact No	
Public/Private Cover	
EDD (Scan)	
Gestation (wks)	
Do you want us to contact the patient directly with an appointment?	

Please detail reason for ultrasound request

Referring Consultant

Name		
Contact no (mobile no preferable) / Bleep		
Hosp/Clinic		
Do you wish to be contacted directly following Ultrasound exam?		
Signed		
Office Use Only	Date of Appointment :	List :
	Charge Yes/No	