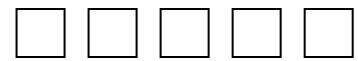

CDSS Children with Down's Syndrome Study

REFERRING HOSPITAL FORM

Please complete this form and return with the white copy of the consent form in the envelope provided.

Mother's name: ______________________________

Mother's Hospital ID number: ______________________________

Baby's name (if known): ______________________________ Baby's gender: M F

Baby's date of birth: ____ / ____ / ________

Baby's hospital ID number: ______________ Baby's NHS no. (if known): ______________

Gestational age: ______________________ Birth weight: ____________ grams

Hospital name: ______________________________

GP name: ______________________________

GP address: ______________________________

____

Is a full blood count sample being sent for the study? Yes ☐ No ☐

Is this a new sample taken specifically for the study? Yes ☐ No ☐

If completed, please return the white copy of the consent form, along with this form using the prepaid envelope addressed to:

CDSS
PO Box 518
SRB, Area 3
York, YO1 0BF

If you have any queries please contact us on:

Freephone: 0800 3280655
Email: cdss@egu.york.ac.uk