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**Referral for suspected familial hypercholesterolaemia**

**For further guidance and referral pathway information please refer to NICE guidance**

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| **ATTN\*** (**✓** only one option) | | | |
| **🞏** | **Tel. no. 023 8120 6483**  **Email. GeneticsFH@uhs.nhs.uk** |  | **FH Clinical Team,**  **Wessex Clinical Genetics Service Princess Anne Hospital, Coxford Road**  **SO16 5YA** |

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| **Date of referral\*** | DD / MM / YYYY | **Clinic required\*** (**✓** only one option) | | **New Patient:** | **Cascade Patient:** |
| **Patient details** | | | | | |
| **Name\*** |  | | | **Date of birth\*** |  |
| **NHS Number \*** |  | | | **Sex** |  |
| Patient address:  Post Code:  Tel. no. Home:  Work: Mobile: | | | | **Referrers name\*:**  **Address\*:**  **Tel. no.\*:**  **Fax no.\*:** | |
| **Medications\***  (please attach GP summary) |  | | | | |
| **Supporting clinical information for referral** | | | | | |
| **Family History\*** |  | | | | |
| **Relevant past medical history\*** |  | | | | |
| **Relevant conditions\*** | 🞏 Diabetes  🞏 Renal Disease | | **Prior CVD\*** 🞏 Yes or 🞏 No  History | | |
| **Fasting Lipid Profile findings\***  (Please attach results) | 🞏 First  **Pre Statin treatment if possible** | | 🞏 Second | | |
| **Routine bloods requested\*** | 🞏 U&Es 🞏 FBC 🞏 TFTs 🞏 LFTs 🞏 Fasting Glucose | | **Statin Medication: Dose:**  Start date | | |