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| **NEONATAL CONJUGATED JAUNDICE REFERRAL**  **FOR PAEDIATRIC HEPATOLOGY**  Completed forms need to be emailed to [kch-tr.PaedLiverRegistrars@nhs.net](mailto:kch-tr.PaedLiverRegistrars@nhs.net)  **Please contact the on call paediatric liver registrar when sending this form**  **On-call registrar: 0203 299 9000 bleep 37810** | | |
| **Patient Details (Please complete all fields)**  **Referral is NOT accepted without filling ALL Fields in this page** | | |
| Patient’s surname: | Date of Birth: | Sex: |
| Patient’s forename: | NHS number: | |
| Home address:  Postcode: | Home telephone number: | |
| Mobile telephone number: | |
| Patient's GP address: | GP telephone number: | |

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| **Referring Organisation (Please complete all fields)**  **Referral is NOT accepted without filling ALL Fields in this page** | |
| Referring consultant name and email: | |
| Referring organisation name: | |
| Referring organisation hospital number: | |
| Name of person completing proforma: | Contact phone:  Bleep: |
| Contact e-mail: |

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| **(Please complete all fields)**  **Referral is NOT accepted without filling ALL Fields in this page** | |
| Are parents aware of referral to King’s? |  |
| Is an interpreter required? If so, which language? |  |
| Pt known to the liver unit in King’s? |  |
| Urgent Case to be discussed by phone (Name of doctor at KCH discussed with) |  |
| Date and time of referral |  |

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| **Clinical details** |
| **Summary (please include clinical summary of patient, particularly including any relevant details for points i-vi)**   1. *Gestation, birth weight, current weight* 2. *Birth history* 3. *Feeding history. If patient had/having parental nutrition, include duration and date stopped* 4. *Infection history (including timelines, severity, courses of antibiotics and culture positivity)* 5. *GI/surgical history (including dates and details of any GI surgery)* 6. *Cardiac/Respiratory/Neurological co-morbidities*   ----------------------------------------------------------------------------------------------------------------------------------------  **Medications**  ----------------------------------------------------------------------------------------------------------------------------------------**Relevant obstetric history (e.g obstetric cholestasis, diabetes)**  ………………………………………………………………………………………………………………………………………………………………..  **Relevant FHx (e.g history of liver disease)**  **Red flag signs (referrals cannot be accepted without completion of the following 4 fields)**   |  |  | | --- | --- | | **Stool Colour**  *(must be observed by medical physician)* | **Pale Not pale**  *(Delete as appropriate)* | | **Liver Ultrasound** | *(please type report)* | | **INR > 1.3** | **Yes No**  *(Delete as appropriate)* | | **Clinically unwell** | **Yes No**  *(Delete as appropriate)* |   **If any red flag signs present, please email this referral form and urgently call KCH Liver Registrar** |

**Baseline Investigations:** Please complete the following baseline bloods prior to sending referral (please state bilirubin trends if available)

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| **Date** |  |  |  |  |  |  |  |
| **Bili T/D** |  |  |  |  |  |  |  |
| **AST** |  |  |  |  |  |  |  |
| **ALT** |  |  |  |  |  |  |  |
| **ALP** |  |  |  |  |  |  |  |
| **GGT** |  |  |  |  |  |  |  |
| **Prot** |  |  |  |  |  |  |  |
| **Alb** |  |  |  |  |  |  |  |
| **Hb** |  |  |  |  |  |  |  |
| **WCC** |  |  |  |  |  |  |  |
| **Neutro** |  |  |  |  |  |  |  |
| **Platelets** |  |  |  |  |  |  |  |
| **INR** |  |  |  |  |  |  |  |
| **PT** |  |  |  |  |  |  |  |
| **APTT** |  |  |  |  |  |  |  |
| **Urea** |  |  |  |  |  |  |  |
| **Creatinine** |  |  |  |  |  |  |  |
| **Blood sugar** |  |  |  |  |  |  |  |
| **Na/K** |  |  |  |  |  |  |  |

**First line Neonatal Conjugated Jaundice Investigations:** Please start sending the following investigations

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| **Test** | **Date sent** | **Result** |
| **Reticulocytes** |  |  |
| **Group and Coombs** |  |  |
| **Triglycerides** |  |  |
| **Cholesterol** |  |  |
| **Ferritin** |  |  |
| **Gal-1-PUT\*** |  |  |
| **Alpha-1-antitrypsin levels \*\***  **(and phenotype if possible)** |  |  |
| **Lactate** |  |  |
| **Urine organic acids** |  |  |
| **Serum amino acids** |  |  |
| **T4/TSH** |  |  |
| **Cortisol** |  |  |
| **Toxoplasma IgM** |  |  |
| **Rubella IgM** |  |  |
| **CMV IgM** |  |  |
| **EBV IgM** |  |  |
| **Hepatitis serology (HepA-HepE)** |  |  |
| **AFP** |  |  |

\***Gal-1-PUT** is a red cell enzyme, which if deficient could represent Galactosaemia. This test is invalid if the child has received a blood transfusion within the previous 6 weeks. In this case parents’ samples should be sent instead for carrier testing.

Note: If an infant is exclusively or partially breastfed and has been advised to change to an exclusive galactose free formula pending Gal-1-Put, please emphasise that this change may only be until Galactosaemia has been excluded. Please encourage mothers to express and freeze their breastmilk to help maintain supply pending results, so that breastfeeding can be more easily resumed once safe to do so.

\*\*Please check if your local lab carries out **alpha-1-antitrypsin phenotyping.** This test is invalid if the child has received a blood transfusion within the previous 6 weeks. In this case parents’ samples should be sent instead for carrier testing.

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| **Updates** (to be completed by KCH hepatology registrar): |