Worcestershire Acute Hospitals NHS Trust

Management Of Suspected/Identified Fetal Anomaly

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Key Documents Owner/Lead:	Dr Hillman	Consultant Obstetrician
Approved by:	Maternity Governance Meeting	
Date of Approval:	24th October 2025	
Date of review:	24th October 2028	

Key Amendments

Date	Amendments	Approved by
12th June 2020	Pregnancy Outcome Request form added to guideline as Appendix 1	
4th June 2024	Document extended for another 12 months whilst under review	Maternity Governance
24th October 2025	Document reviewed and approved with no changes	Maternity Governance

Introduction

In the event of suspected/identified fetal anomaly, the woman will be informed of the findings and given the option to discuss these further with the on call Consultant /Screening Team/or Antenatal Clinic team. A referral to the Antenatal Screening Team will be performed via the designated form to gain access to the local fetal medicine service.

Appropriate support should be provided to Parent(s) to ensure effective communication, who do not understand or speak English or who have other special needs (e.g. interpretation and sign language services).

Note: This pathway has been reviewed in line with NHS Fetal Anomaly Specification Screening Programme (Standards and Service specifications).

Guideline

Pathway for Suspected Fetal Abnormalities

Notification of suspected fetal anomaly may be received from various sources i.e.

- Ultrasound Department.
- Emergency Pregnant Assessment Unit (EPAU)
- Birmingham Cytogenetics Laboratory
- Other Private Services

And reported to:

- Antenatal Screening Midwives
- Antenatal Clinic Midwives at WRH, Redditch and Kidderminster
- Obstetric Consultant, if appropriate

NOTE: If the Screening Midwives and Antenatal Clinic Staff are unavailable, delivery suite should be contacted.

Upon receipt of notification of suspected anomaly, the action plan is as follows:

1. Patient reviewed in Antenatal Clinic/Delivery Suite with scan report by antenatal screening team/ANC midwives. If required, the On-Call Consultant should be contacted to further discuss the findings with the patient. Document the discussion/action taken in the patient maternity records.

2. A referral (Appendix 1) will be made to the screening team, who will contact the patient within 24 hours (working days) to offer fetal medicine scan and review. Discussion should include sufficient information to ensure that the woman is aware of the purpose, benefits, limitations and implications of undergoing further investigations

   Upon receipt of form, the referral will be triaged on an individual basis; a fetal medicine appointment will be made locally within 3 working days, as per national standards (where capacity allows). An email referral to Birmingham Women's Hospital Fetal Medicine Unit (BWH) (Appendix 2) will be sent screening coordinator/antenatal clinic manager if review at a tertiary centre is more appropriate.

   BWH will then contact the patient directly (see Referral form Appendix 1.) This appointment will be offered within 5 working days as per national standards. Following the appointment, a detailed report and suggested plan of care will be sent to the screening team via the generic email.

3. If the woman declines any further investigation/interventions, she should still be seen by the obstetric consultant who should document the discussion in her maternity notes after careful counselling. Further follow up and appointments should be offered for routine antenatal consultant care.
4. If pregnancy on-going, the fetal medicine consultant/screening midwife will complete an Antenatal Paediatric Referral (blue paediatric referral form). (Appendix 3)

   If indicated, the National Congenital Anomaly and Rare Disease Registration Service (NCARDRS) antenatal form (Appendix 4) will be completed and sent by the screening team.

5. If termination of pregnancy is discussed/offered and the client wishes to terminate the pregnancy she should be counselled by the consultant who should consent her and complete the Abortion Act Form (refer to relevant pathways depending on gestation – XXX or 'Management of medical termination of pregnancy using mifepristone/misoprostol for fetal abnormality or intrauterine death from 20 weeks'). Consultant to prescribe treatment as per guideline.

   The screening coordinator/midwife then:

   Liaises with ward and bereavement team for admission date
   (Up to 16 weeks Gynae inpatient area. After 16 weeks Delivery suite)
   NOTE: Terminations from 21^{+6} days onwards up to 23+6 will require FETOCIDE first – this should be Consultant to Consultant referral with Fetal Medicine Unit at Birmingham Women's Hospital.

Appendix 1 – Worcestershire Royal Hospital Fetal Medicine Referral

FETAL MEDICINE USS REQUEST FORM

Screening Team: 01905768945

Email Form to: wah-tr.AntenatalScreeningResults@nhs.net

REFERRAL DETAILS					
Referral date		Name and telephone extension number of referrer			
Hospital				Obstetrician	

PATIENT DETAILS			
Hospital number		Address	
First name			
Surname			
NHS Number			
Date of Birth			
GP Name		Postcode	
GP Address		Tel Home	
		MOBILE	
		Tel other	
First language		Interpreter Needed	

OBSTETRIC HISTORY			
Parity		EDD by scan	
Other relevant results i.e. screening		Gestation	

INDICATION FOR REFERRAL (please give outline, relevant blood results, USS, should be available on ICE)

FOR SCREENING TEAM ONLY:	REQUEST DECLINED: REASON/PLAN
FOR FETAL MED SCAN **YES / NO**	RETURN TO SENDER:
APPT:	
LETTER SENT:	
THREE WORKING DAYS:	
DATIX:	

If scan request declined, it is the responsibility for the referring person to inform patient and ensure plan in place

Appendix 2 – Birmingham Women's Health Care Fetal Medicine Referral

Birmingham Women's Health Care NHS
NHS Trust
WEST MIDLANDS FETAL MEDICINE CENTRE
Tel: 0121 627 2683
Email: f.medicine@nhs.net

Detailed scan referral form

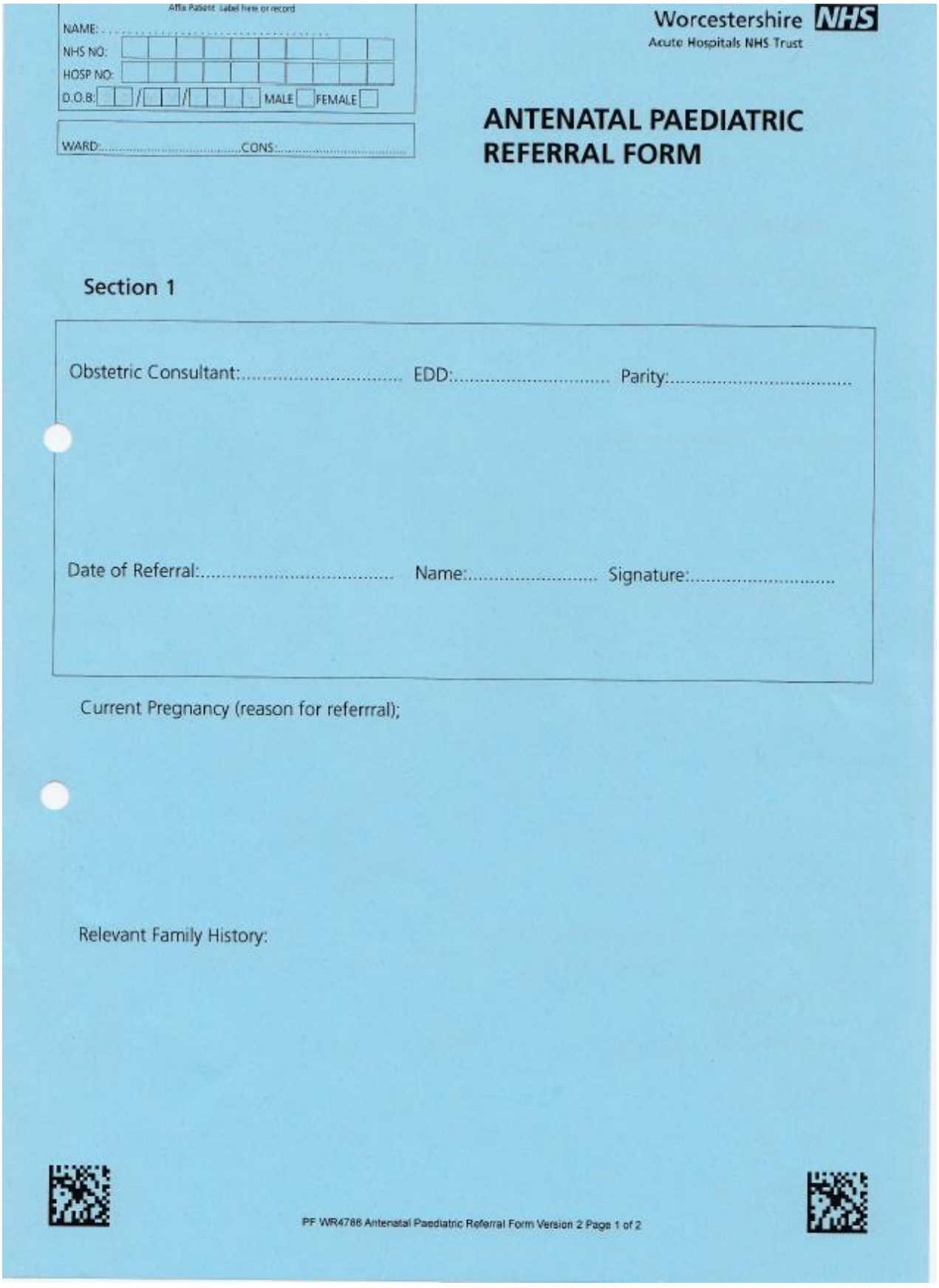
REFERRAL DETAILS			
Referral Date		Name of referrer	NIKKI WILCOX
Hospital	WRH	Hospital number	
Obstetrician			
Hospital contact name & tel number	NIKKI WILCOX 01905 768945		

PATIENT DETAILS			
First name			
Surname			
NHS No			
Date of birth			
		Tel No	
Height		Weight	
Safeguarding Issues	NO		
First Language	ENGLISH	Interpreter needed?	NO

OBSTETRIC HISTORY			
Gestation		EDD by scan	
Blood Group (Send hard copy)		HIV Status (Send hard copy)	
Screening / Karyotype result if performed			

PREVIOUS OBSTETRIC HISTORY			
Gravida		Parity	
Living Children	< 37 weeks ☐	> 37 weeks ☐	
Neonatal deaths	< 37 weeks ☐	> 37 weeks ☐	
Miscarriages	< 15 weeks ☐	16-23 weeks ☐	4-36 weeks ☐ > 37 weeks ☐
Terminations	< 15 weeks ☐	16-23 weeks ☐	

INDICATION FOR REFERRAL (PLEASE ALSO SEND SCAN REPORTS / RELEVANT RESULTS)	
Next appointment date at local maternity unit	TBC



Affix Patient Label here or record

NAME: .....

NHS NO:

HOSP NO:

D.O.B: / / MALE FEMALE

WARD:..... CONS:.....

Worcestershire NHS
Acute Hospitals NHS Trust

ANTENATAL PAEDIATRIC REFERRAL FORM

Section 1

Obstetric Consultant:..... EDD:..... Parity:.....

Date of Referral:..... Name:..... Signature:.....

Current Pregnancy (reason for referrral);

Relevant Family History:

PF WR4786 Antenatal Paediatric Referral Form Version 2 Page 1 of 2

Affix Patient Label here or record

NAME: .....

NHS NO:

HOSP NO:

D.O.B: / / MALE FEMALE

WARD: ..... CONS: .....

Section 2 (Care Pathway)

Antenatal Management Plan:

Intrapartum Management Plan:

Postnatal Management Plan:

Lead Paediatrician:

Print Name:..... Signture:.....

Date:...../...../.....

Appendix 4 - Antenatal NCARDRS form

Public Health England

National Congenital Anomaly and Rare Disease Registration Service (NCARDRS)

Data collection form – Antenatal

Please notify any suspected or confirmed anomaly identified antenatally – structural, chromosomal or biochemical.
DO NOT WAIT until final confirmation before sending this form.

Authorised under Section 251 of the NHS Act 2006 to collect information without patient consent (CAG 10-02(b)(2015))

For office use only

MOTHER'S DETAILS

(Sticky label, if available)

Surname:
Forename:
Hosp. no:
NHS no:
Address at booking:
Postcode: Date of birth:
Ethnic category: White Mixed Indian Pakistani
Bangladeshi Other Asian* Black Caribbean Black African
Other Black* Chinese Other* Not known
*If other, please state:
Occupation:

BOOKING DETAILS

Date of 1st booking appointment:
Booking hospital:
EDD:
Height: cm Weight: kg BMI:
Smoking status: Current Ex Non Never Not known
Weekly alcohol units at booking:
Substance use at booking: Yes No Not known
If yes, substance:
Prescription drugs (1st trimester) inc. dose:
Maternal illnesses:
Folic acid: Pre and post conception Post conception only
Taken, timing unknown Not taken Not known
If taken, dose: Standard 400mcg High 5mg
Assisted conception: Yes No Not known
If yes, type: Ovulation induction IVF ICSI Not known
Number of previous live births:
Number of previous stillbirths (24+ weeks, incl. TOPs):
Number of previous losses (<24 weeks, incl. TOPs):
Number of previous neonatal deaths:
Previous congenital anomalies:
Father's age at booking: years
Family history of anomalies:
Maternal:
Paternal:
Consanguinity: No Yes, 1st cousin Yes, 2nd cousin
Yes, other Yes, relation nk Not known

PREGNANCY DETAILS

Number of fetuses:
Twin type/chorionicity:

Please attach copies of any relevant scans/clinic letters/laboratory or post mortem reports.

Return forms to: NCARDRS West Midlands Regional Office, Public Health England, First Floor, 5 St Philip's Place, Birmingham, B3 2PW (using secure pre-paid return envelope) or email phe.wmcar@nhs.net (from your own NHS.net email account)

Click to lock all form fields and prevent future editing

ANEUPLOIDY SCREENING DETAILS

Date (specimen) Test Result
Combined Accepted
T21 risk: 1 in T13/18 risk: 1 in
Quad Declined Not offered Reason
NIPT Positive Negative Inconclusive
Risk: 1 in

DIAGNOSTIC TEST DETAILS

Date (procedure) Sample Result
CVS Normal Abnormal Declined
Amnio Offered Not offered Reason
Fetal blood Other, specify:
Karyotype/microarray:

ANTENATAL SCAN DETAILS

1st trimester (dating) scan:
Date USS findings *(attach report)*
Normal Abnormal Incomplete
NT measurement mm

Fetal anomaly (18^{+0} – 20^{+6}) scan:
1st attempt USS findings *(attach report)*
Date Normal Abnormal Incomplete Not known
Not done, give details:
2nd attempt USS findings *(attach report)*
Date Normal Abnormal Incomplete
Not done, give details:

Echo/MRI/Other:
Date Findings *(attach report)*

REFERRAL DETAILS

Department/Hospital:
Consultant:

ADDITIONAL DETAILS

Use this box/back of the form to extend answers or include any extra information you think is relevant

NOTIFIER DETAILS

Name:
Hospital:
Department:
Email:
Tel: Date:

Public Health England

National Congenital Anomaly and Rare Disease Registration Service (NCARDRS)

Data collection form – Postnatal

Please notify any confirmed anomaly – structural, chromosomal or biochemical.
One form per affected baby

Authorised under Section 251 of the NHS Act 2006 to collect information without patient consent (CAG 10-02(b)(2013))

For office use only

BABY'S DETAILS

(Sticky label, if available)

Surname:
Forename(s):
Hosp. no:
NHS no:
Address at birth:
Postcode:
Date of birth:
Sex: ○ Male ○ Female ○ Indeterminate ○ Not known

BIRTH DETAILS

Place of delivery:
Type of delivery: ○ Spont. vertex ○ Spont. other ○ Low forceps ○ Other forceps ○ Ventouse ○ Breech ○ Breech extraction ○ Elective CS ○ Emergency CS ○ Other, specify ○ Not known
Birth weight: g Birth order: of
Gestation at delivery: weeks + days

MOTHER'S DETAILS (if known)

(Sticky label, if available)

Surname:
Forename:
Hosp. no:
NHS no:
Address at booking:
Postcode:
Date of birth:
Booking hospital:

BABY'S DEATH DETAILS (if applicable)

Date of death:
Post mortem: ○ Yes ○ Not requested ○ Not permitted ○ Requested but not performed ○ Not known

BABY'S PROCEDURE DETAILS (if applicable)

Date/age performed/ expected	Department/ Doctor	Procedure

NOTIFIER DETAILS

Name:
Hospital:
Department:
Email:
Tel: Date:

ANOMALY DETAILS – LIST ALL

Anomaly	Suspected prenatally	How confirmed? E.g. cytogenetics, x-ray, PM
	○ Yes ○ No	Date confirmed
	○ Yes ○ No	Date confirmed
	○ Yes ○ No	Date confirmed
	○ Yes ○ No	Date confirmed
	○ Yes ○ No	Date confirmed
	○ Yes ○ No	Date confirmed
	○ Yes ○ No	Date confirmed
	○ Yes ○ No	Date confirmed

ADDITIONAL DETAILS

Use this box/back of the form to extend answers or include any extra information you think is relevant (including future referrals and treatments)

Please attach copies of any relevant scans/clinic letters/laboratory or post mortem reports.

Return forms to: NCARDRS West Midlands Regional Office, Public Health England, First Floor, 5 St Philip's Place, Birmingham, B3 2PW (using secure pre-paid return envelope) or email pha.wmcar@nhs.net (from your own NHS.net email account)

Click to lock all form fields and prevent future editing

Appendix 5 – Preganancy Outcome Request Form

DEPARTMENT OF FETAL MEDICINE
C/O ANTENTATAL CLINIC
WORCESTERSHIRE ROYAL HOSPITAL
CHARLES HASTINGS WAY
WORCESTER
WR5 1DD

PREGNANCY OUTCOME REQUEST FORM

PATIENT:

REFERRAL REASON/DIAGNOSIS:

EDD:

DATE OF DELIVERY: GESTATION:

PLACE OF DELIVERY:

OUTCOME OF PREGNANCY: live birth/miscarriage/stillbirth/termination

BIRTHWEIGHT + CENTILE:

ADDITIONAL INFORMATION:

PLEASE COMPLETE THE ABOVE AND RETURN TO
wahtr.antenatalscreeningresults@nhs.net

FETAL MED TEAM ONLY:

FOR MDT/IMAGE REVIEW: YES/NO IF YES:
FETAL MEDICINE
JOINT FETAL MEDICNE/PEADIATRICS