

**SELF REFERRAL FOR ANTENATAL CARE**

**Please write legibly when completing this form and complete the form fully**

**GP name and Practice** ……………………………………………………………..

 **(**Full address / stamp please)

Tel No:……………………………………..Fax No:………………………………….

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| --- |
| **PATIENT’S DETAILS** |
| NHS number: | Hospital number:*If known* |
| Family name: | Given name: |
| Previous name: | Date of birth:*(Required)* |
| Address: |
| Home phone: | Mobile no:  |
| Country of birth: | Date of entry to UK: |
| Ethnic group: | Interpreter required? Y/NIf yes, please state language  |

|  |
| --- |
| **HISTORY** |
| **CURRENT PREGNANCY**  |
| LMP: | EDD: | Gestation at referral: |
| Late Bookers (>12 weeks)Transferring care from another unit Y/N Un-booked Y/N |
| **PREVIOUS OBSTETRIC HISTORY** |
| No. of Pregnancies |  | No. of Live births  |  |
| No. of Miscarriages < 12 weeks  |  | No. of Miscarriages > 12 weeks |  |
| No. of Stillbirths  |  | No. of Neonatal deaths |  |
| No. of Termination of Pregnancies  |
| *Known genetic problems, please specify* |
| Previous LSCS *(Lower [uterine] segment caesarean section)*  | Yes | No |
| Medical History |
| Allergies: | Medication: |
| Height: | Weight: | BMI: |

**INCREASED RISK REFERRALS**

**Please tick all relevant boxes:**

|  |  |
| --- | --- |
| **1. Medical Increased Risk** * IVF
* Twins
* PET
* SLE
* Hypertension
* Renal Disease
* Epilepsy
* Liver Disease
* Neurological disorders
* Cardiac Disease
* Thrombophillia
* Tumours
* Previous Thrombosis
* TB
* Sickle cell disease
* HIV
* Any haemoglobinophathy abnormality, please state if known
* Partner’s haemoglobinophathy status if known
 | **2. Psycho-Social Risk Factors** * + Mental Health Problems
	+ Child protection concerns
	+ Alcohol Misuse (including partner)
	+ Domestic Abuse
	+ Substance misuse (including partner)
	+ Smoker
	+ Learning Difficulties
	+ Asylum seeker

**3. Diabetes – Endocrinology*** Pre-existing diabetes Type 1
* Pre-existing diabetes Type 2
* Hyper/hypothyroidism
* Previous gestational diabetes
* Abnormal GTT
* Auto Immune thyroid disorder
* Other Endocrine problems
 |
| Please detail any increased risk factor not listed above / additional comments  |

Signature…………………………………

Print……………………………………….Date…………………………………