

**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/N  If 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…………………………………