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**King's Maternity Antenatal**

**Self-Referral Form**

You can choose to refer yourself directly to the antenatal services at King’s College Hospital, rather than via your GP. Please complete this form, giving as much detail as possible so that we can ensure the best pathway for your maternity care. The information you provide will be placed in your medical records and only accessed by staff involved in your care.  Please be aware we liaise with relevant partner agencies as required, read more about your rights in our [Privacy Policy](https://www.kch.nhs.uk/about/corporate-information/our-policies-and-procedures/).

Please save this Word document, fill in the form and send completed forms as an attachment to **kch-tr.antenatalreferral@nhs.net**.Appointment letters will be sent out in the post.

*It will take you approximately 15 minutes to complete this form.*

**Part 1 – To be completed by the referrer** (go to Part 2 if not applicable)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Are you completing this referral on behalf of another person? |  Yes |  | No |  |

|  |  |
| --- | --- |
| Referrer Name: |  |
| Referrer Email: |  |

**Part 2 – Personal Information**

|  |  |
| --- | --- |
| First Name: |  |
| Surname: |  |
| *Previous Surname:* |  |
| Date of Birth: |  |
| Place of Birth: |  |
| Telephone Number: |  |
| Email Address: |  |
| NHS Number (if known): |  |
| Address: |  |
| Town/City: |  |
| Postcode: |  |
| GP Practice: |  |
| GP Telephone: |  |

**Part 3 – Social Information**

**Sensitive information – why do we ask?**

This form contains questions asking about your mental health, whether you are experiencing domestic abuse and if there is any involvement with social services and your family. This is so your referral can be directed to the most appropriate care team at the earliest opportunity. We have specialist teams and work with other professionals to provide holistic care during your pregnancy, birth and postnatal period.

Please remember your maternity team are here to support you with any difficulties during your pregnancies. Speak to your community midwife, GP or maternity assessment unit if you have any concerns.

|  |  |
| --- | --- |
| Gender Identity: |  |
| Sexuality: |  |
| Preferred Pronouns: |  |
| Religion: |  |
| Occupation: |  |
| Marital Status: |  |

**Ethnic group of people who use our services.**

We aim to give you the best possible health care. The details of your ethnic group that you give us will help us to plan and develop our services so that they meet the needs of everybody who uses them, whatever their background. We want to ensure that people from all the diverse ethnic groups in our community have appropriate health care and equal access to services at King’s.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Ethnicity that best describes you:Reference: [Gov.UK 2021 census list of ethnic groups](https://www.ethnicity-facts-figures.service.gov.uk/style-guide/ethnic-groups) |  **Asian or Asian British**

|  |  |  |  |
| --- | --- | --- | --- |
| Indian |  | Pakistani |  |
| Bangladeshi |  | Chinese |  |
| Any other Asian background |  |  |  |

 **Black, Black British, Caribbean, or African**

|  |  |  |  |
| --- | --- | --- | --- |
| Caribbean |  | African |  |
| Any other Black, Black British, or Caribbean background |  |

 **Mixed or multiple ethnic groups**

|  |  |  |  |
| --- | --- | --- | --- |
| White and Black Caribbean |  | White and Black African |  |
| White and Asian |  |  |  |
| Any other Mixed or multiple ethnic background |  |

 **White**

|  |  |
| --- | --- |
| English, Welsh, Scottish, Northern Irish or British |  |
| Irish |  | Gypsy or Irish Traveller |  |
| Roma |  | Any other White background |  |

 **Other ethnic group**

|  |  |  |  |
| --- | --- | --- | --- |
| Arab |  | Any other ethnic group |  |

 |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Do you require an interpreter or British Sign Language? |  Yes |  | No |  |

|  |  |
| --- | --- |
| Please state interpreter language: |  |
| Do you have any mobility, sight, hearing, or other specific needs that we should be aware of to help prepare for your appointment? |  |
| Next of Kin Name: |  |
| Next of Kin Relationship: |  |
| Next of Kin Contact: |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Are any of the following relevant to you? |  Yes |  | No |  |

***If answer is Yes, you must provide further details under additional information***

|  |  |  |  |
| --- | --- | --- | --- |
| Substance use (self) |  | Substance use (partner) |  |
| Safeguarding (known to social services) |  | Domestic abuse or violence |  |
| Asylum seeker or Refugee |  | Psychiatric history |  |

|  |  |
| --- | --- |
| Additional Information: |  |
| Care team contact details: |  |

**Part 4 – Medical History**

We have specialist teams of midwives and doctors to provide support for parents withadditional medical or mental health needs.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Are any of the following relevant to you? |  Yes |  | No |  |

***If answer is Yes, you must provide further details under additional information.***

|  |  |  |  |
| --- | --- | --- | --- |
| Epilepsy |  | Bowel problems |  |
| Heart problems |  | Kidney problems |  |
| Liver problems |  | Lung problems |  |
| Gastrointestinal problems |  | Haematological problems |  |
| Neurological problems |  | Rheumatology problems |  |
| Current gestational diabetes (GDM) |  | Type 1 or 2 diabetes |  |
| Gynaecological problems |  | Hypertension or high blood pressure |  |
| Current cancer |  | Cystic Fibrosis |  |
| HIV |  | Hepatitis |  |
| Syphilis |  | Previous blood clot in lung or legs |  |
|  |  | Other (specify below) |  |
| If you have a medical history, please share additional information (for instance; date of diagnosis, current treatment plan): |  |
| Details of secondary care team (team, location, best email contact): |  |
| Are you currently prescribed any medications? If so, please share the details here. |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Do you smoke? |  Yes |  | No |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Cigarettes |  | Rollups |  |
| Vape |  | Other |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Do you (or father of baby) have sickle cell disease or trait? |  Yes |  | No |  |
| Do you (or father of baby) have thalassemia disease or trait? |  Yes |  | No |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Have you had a cervical smear test? |  Yes |  | No |  |

|  |  |
| --- | --- |
| Date and outcome of last cervical smear test: |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Have you had any of the following? |  Yes |  | No |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Colposcopy |  | LLETZ |  |
| Cervical biopsy |  | Cautery (diathermy) to cervix |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Do you have any problems with your mental health and wellbeing? |  Yes |  | No |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Current |  | Past |  |

Mental health screening - in the past month have you:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Felt down, depressed, or hopeless? |  Yes |  | No |  |
| Felt little interest or pleasure in doing things? |  Yes |  | No |  |
| Felt nervous, anxious or on edge? |  Yes |  | No |  |
| Not been able to stop or control worrying? |  Yes |  | No |  |
| None of the above |  Yes |  | No |  |

|  |  |
| --- | --- |
| If you answered yes to any of the mental health screening questions, is this something you want or need help with? |  |
| Is there anything else you would like to add about your mental wellbeing? |  |

**Part 5 – Pregnancy Information**

The following questions help us to understand your situation, when you will need your first scan, and what kind of maternity care you might need. Please answer as best you can. We will discuss your responses further at your first appointment.

|  |  |
| --- | --- |
| First day of your last menstrual period (LMP): |  |
| Is there any further information you want provide, such as a date of conception or an estimated first day of last menstrual period? |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Are you transferring your care from another healthcare provider? |  Yes |  | No |  |

|  |  |
| --- | --- |
| If yes, please provide name and location of care provider: |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Have you had an ultrasound scan during this pregnancy? |  Yes |  | No |  |
| If so, please let us know the due date from scan: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  |
| Was this pregnancy conceived with in vitro fertilisation (IVF)? |  Yes |  | No |  |
| If IVF, please let us know the egg transfer date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Is this your first pregnancy? | Yes |  | No |  |
| If not, please let us know number of previous pregnancies: \_\_\_\_\_\_\_\_\_\_ |
| How many living children do you have? \_\_\_\_\_\_\_\_ |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Are any of the following relevant to you? |  Yes |  | No |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Babies born premature (before 37 weeks) |  | Ectopic pregnancy |  |
| Miscarriage |  | Stillbirth |  |
| Termination of pregnancy |  | Neonatal death |  |

How many times have you given birth the following ways?

|  |  |  |  |
| --- | --- | --- | --- |
| Vaginal birth (no suction or forceps) |  | Forceps |  |
| Ventouse (suction) |  | Caesarean section |  |

**Part 6 – Place of birth preferences**

**Please share your thoughts on where you would like to give birth.**You can choose from homebirth, midwife-led unit (MLU) and obstetric-led unit (Labour Ward). Each option has risks and benefits which will be unique to you. Your care team will discuss your options with you during your pregnancy.

If this is your first baby, you can read more about this in the leaflet *'Your choice where to have your baby'* <https://assets.nhs.uk/prod/documents/NHSE-your-choice-where-to-have-baby-first-baby-sept2018.pdf>

If you are interested in homebirth and would like to speak to someone before your first booking appointment, please select 'Interested in homebirth' and a midwife will contact you to discuss this option.

|  |
| --- |
| Preferred place of birth: |

|  |  |  |  |
| --- | --- | --- | --- |
| Homebirth |  | Midwife-led Suite |  |
| Interested in homebirth |  | Obstetric-led Labour Ward |  |
| Undecided |  |  |  |

**Part 7 – Digital maternity record**

**Your digital pregnancy records will be held with https://www.badgernotes.net/**If you would like to see your pregnancy records online, confirm your consent for this. We will setup your account with secure three-step verification, which is important because it ensures your personal health records can only be accessed by you. Your email address will only be used by the hospital to contact you regarding this pregnancy. It will be shared with Clevermed Ltd, the company that provides the Maternity notes system. It will not be shared with any other external organisations. For further information about how your data will be used and stored, visit <https://www.badgernotes.net/home/privacynotice>

Please note: our digital patient management system is changing on the 5th of October 2023. Read more about the new system, Apollo, on our [webpage here](https://www.kch.nhs.uk/about/our-strategy/electronic-health-record/).

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| I consent to accessing my records on an electronic system. |  Yes |  | No |  |

|  |  |
| --- | --- |
| Confirm the mobile phone number to access your maternity records online: |  |
| Confirm the email address to access your maternity records online: |  |

**Thank you.**

Please save this form and email to kch-tr.antenatalreferral@nhs.net

Phone: 020 3299 8131

Post: Antenatal Clinic, Kings College Hospital Denmark Hill London SE5 9RS

How satisfied were you with the referral process?

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Not satisfied |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  1 |  2 |  3 |  4 |  5 |  6 |  7 |  8 |  9 |  10 |

 | Very satisfied |

**For office use only**

|  |  |  |  |
| --- | --- | --- | --- |
| Hospital ID: |  | NHS Number: |  |
| Midwife team: |  | Midwife appointment: |  |
| LMP: |  | EDD: |  |
| Weeks pregnant at referral: |  | Scan appointment: |  |
| Notes: |  |