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| **PATIENT** |
| Surname |  | Date of Birth |  |
| First name |  | Ethnicity |  |
| Previous Name |  | If interpreter required, state language: |
| Address and postcode |  |
| Email |  | NHS Number |  |
| Mobile number |  |
| Next of Kin |  | Relationship |  |
| Contact number |  |
| **GP / MEDICAL REFERRER** |
| Name |  | GP Practice / Department |  |
| Address |  | Telephone number |  |
| **Current Pregnancy** |
| Estimated last menstrual period**\*** |  | Estimated Delivery Date (EDD) |  |
| Weeks pregnant at referral |  | Is an early pregnancy scan required: (prior to 12/40) | Yes No [ ]  |
| **Past Obstetric History** *(Note any previous caesarean section, assisted delivery, and pregnancy outcomes)* |
| No. of previous pregnancies: |  | No. of still birth: |  | No. of miscarriages/ TOP |  |
| No. of live children: |  | No. of neonatal death: |  | No. of pre-term babies:(Less than 37 weeks) |  |
| Mode of delivery(s): |  | No. of ectopic pregnancies: |  |
| **Any other issues (such as assisted conception or complications of pregnancy**):  |
| **Medical history** *(if answer is Yes to any of the following,* ***you must*** *provide further details using the ‘additional information’ section)* |
| Cardiac | Yes [ ]  No [ ]  | Neurological | Yes [ ]  No [ ]  |
| Respiratory | Yes [ ]  No [ ]  | Diabetes | Yes [ ]  No [ ]  |
| Sickle Cell/thalassemia | Yes [ ]  No [ ]  | Renal | Yes [ ]  No [ ]  |
| Hypertension | Yes [ ]  No [ ]  | Hepatic | Yes [ ]  No [ ]  |
| Gastrology | Yes [ ]  No [ ]  | CF | Yes [ ]  No [ ]  |
| Haematology | Yes [ ]  No [ ]  | Current cancer | Yes [ ]  No [ ]  |
| Rheumatology | Yes [ ]  No [ ]  | Other (i.e. Disability) | Yes [ ]  No [ ]  |
| **Additional information (for instance; date of diagnosis, current treatment plan including medication)** |
| **Details of secondary care team (team, location, email contact):**  |
| **Social History:***(if answer is Yes to any of the following,* ***you must*** *provide further details using the ‘additional information’ section)* |
| Substance abuse (including partner) | Yes [ ]  No [ ]  | Psychiatric history | Yes [ ]  No [ ]  |
| Violence / domestic abuse | Yes [ ]  No [ ]  | Asylum seeker/refugee/ recourse to funds | Yes [ ]  No [ ]  |
| Safeguarding / known to Social Services | Yes [ ]  No [ ]  | Smoker | Yes [ ]  No [ ]  |
| **Additional information** |
| **Any other professionals involved in care (team, location, email contact):** |

When complete, please email to: kch-tr.antenatalreferral@nhs.net