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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