

**IMPERIAL ANTENATAL REFERRAL FORM**

**MATERNITY HELPLINE: 020 3312 6135**

**REFER VIA EMAIL TO** [ICHC-tr.imperialreferrals@nhs.net](mailto:ICHC-tr.imperialreferrals@nhs.net)

**Please ensure the NHS number & up to date telephone number are documented**

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| **PATIENT** | | | | | | | | | | | | **REFERRER** | | | | | | | | | |
| Name | <Patient name> | | | | | | | | | | | Name | | | <GP name> | | | | | | |
| **NHS Number** | <NHS number> | | | | | | | | | | | GMC/HPC/NMC No | | |  | | | | | | |
| Patient’s Address | <Patient address> | | | | | | | | | | | Practice Address | | | <Current organisation address> | | | | | | |
| Home number | <Patient contact details> | | | | | | | | | | | Telephone | | | <Current organisation details> | | | | | | |
| **Mobile number** | <Patient contact details> | | | | | | | | | | | Fax | | | <Current organisation details> | | | | | | |
| Work number | <Patient contact details> | | | | | | | | | | | NHS.net mail only | | |  | | | | | | |
| Email | <Patient contact details> | | | | | | | | | | | National Practice Code | | | | <Current organisation details> | | | | | |
| Fax |  | | | | | | | | | | |  | | | |  | | | | | |
| DOB | <Date of birth> | | | | | Gender: <Gender (configurable)> | | | | | | Ethnicity: <Ethnicity> | | | | | | | | | |
| Physical/Communication difficulties (specify if any): | | | | | | | | | | | | If interpreter required, state language: | | | | | | | | | |
| **Current Pregnancy** (*Items marked ‘***\****’ are mandatory)* | | | | | | | | | | | | | | | | | | | | | |
| Estimated Last Menstrual Period**\*** | | | | <Numerics> | | | | Estimated Delivery Date | | | | | | | | | | <Numerics> | | | |
| Approximate Gestation at referral | | | |  | | | | Details of any admission or referrals during this pregnancy | | | | | | | | | |  | | | |
| **Past Obstetric History** *(Note any previous caesarean section, assisted delivery, and pregnancy outcomes)* | | | | | | | | | | | | | | | | | | | | | |
| No. of previous pregnancies: | | | |  | No. of still births: | | | | | | | |  | No. of miscarriages | | | | | | |  |
| No. of live children: | | | |  | No. of neo-natal death: | | | | | | | |  | No. of pre-term babies:  (Less than 37 weeks) | | | | | | |  |
| No. of terminations | | | |  | No. of ectopic pregnancies: | | | | | | | |  |  | | | | | | |  |
| Any other issues (such as assisted conception, complications or pregnancy): | | | | | | | | | | | | | | | | | | | | | |
| **Medical and Psychiatric History***(if answer is Yes to any of the following, please provide further details using the ‘additional information’ section)* | | | | | | | | | | | | | | | | | | | | | |
| Cardiac | | Yes  No | | | | | | | Neurological | | | | | | | | Yes  No | | | | |
| Respiratory | | Yes  No | | | | | | | Diabetes | | | | | | | | Yes  No | | | | |
| Haemoglobinopathy | | Yes  No | | | | | | | Renal | | | | | | | | Yes  No | | | | |
| Hypertension | | Yes  No | | | | | | | Hepatic | | | | | | | | Yes  No | | | | |
| Psychiatric | | Yes  No | | | | | | | Other | | | | | | | | Yes  No | | | | |
| **Social History (INCLUDE HERE ANY HISTORY OF TEENAGE PREGNANCY, PREVIOUS CHILDREN ON ‘ AT RISK’ REGISTER, HOUSING ISSUES, IF PATIENT HAS SMOKED IN LAST 6 MONTHS ,ETC)**  *(if answer is Yes to any of the following, please provide further details using the ‘additional information’ section)* | | | | | | | | | | | | | | | | | | | | | |
| Substance abuse (including partner) | | | | | | | Yes  No | | | | Any other mental health concerns | | | | | | | | | Yes  No | |
| Violence / domestic abuse | | | | | | | Yes  No | | | | Any disability | | | | | | | | | Yes  No | |
| Safeguarding / Known to Social Services | | | | | | | Yes  No | | | | Smoker | | | | | | | | | Yes  No | |
|  | | | | | | | | | | | | | | | | | | | | | |
| **Physical Examination of Heart and Lungs** | | | | | | | | | | | | | | | | | | | | | |
| Booking and previous blood pressure | |  | | | | | | | Body Mass Index | | | | | | | |  | | | | |
| Heart | |  | | | | | | | Lungs | | | | | | | |  | | | | |
| **Additional Information** | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
| **Current Medication** | | | | | | | | | | | | | | | | | | | | | |
| <Medication(table)>  Folic Acid: Yes  No  Vitamin D: Yes  No  Other: | | | | | | | | | | | | | | | | | | | | | |
| For Hospital use only: | | | | | | | | | | | | | | | | | | | | | |
| Date on Booking Letter | | | /       / | | | | | | | Antenatal Clinic Appointment Date | | | | | | | | | /       / | | |
| Scan Date | | | /       / | | | | | | | Heart / Lung Appt Date | | | | | | | | | /       / | | |
| Care Type: Midwifery Led / Obstetric Led | | |  | | | | | | |  | | | | | | | | |  | | |
| Further information at [Birth Choice UK](http://www.birthchoiceuk.com/BirthChoiceUKFrame.htm?LocatorFrame.htm?Hospitals/85.htm) or [NHS Choices](http://www.nhs.uk/ServiceDirectories/Pages/ServiceSearchAdditional.aspx?ServiceType=Maternity) | | | | | | | | | | | | | | | | | | | | | |
| **Medical History from GP system** | | | | | | | | | | | | | | | | | | | | | |
| <Summary(table)>  **Allergies**  <Allergies & Sensitivities(table)> | | | | | | | | | | | | | | | | | | | | | |