

**IMPERIAL ANTENATAL REFERRAL FORM**

**MATERNITY HELPLINE: 020 3312 6135**

**REFER VIA EMAIL TO** ICHC-tr.imperialreferrals@nhs.net

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

|  |  |
| --- | --- |
| **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)> |