

**OBSTETRIC MEDICINE PRE-PREGNANCY COUNSELLING**

**DE SWIET OBSTETRIC MEDICINE CENTRE, 2FLOOR, QUEEN CHARLOTTE’S & CHELSEA HOSPITAL, DU CANE ROAD, LONDON W12 0HS**

**TEL: 020 8383 5108**

**TO MAKE REFERRAL PLEASE FAX FORM TO: 020 3313 3507**

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

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **PATIENT** | | | | **REFERRER** | | | | |
| Name | ~[Title]. ~[Forename] ~[Surname] | | | Name | | ~[Free Text:Name of referring clinician] | | |
| **NHS Number** | ~[NHS Number] | | | GMC/HPC/NMC No | |  | | |
| Patient’s Address | ~[Patient Address Block]  ~[Post Code] | | | Practice Address | | ~[Surgery Address Line 1]  ~[Surgery Address Line 2]  ~[Surgery Address Line 3]  ~[Surgery Address Line 4]  ~[Surgery Address Line 5] | | |
| Home number | ~[Telephone Number] | | | Telephone | | ~[Surgery Tel No.] | | |
| **Mobile number** | ~[Mobile Number] | | | Fax | |  | | |
| Work number |  | | | NHS.net mail only | |  | | |
| Email | ~[Email 1] | | | National Practice Code | | | ~[Practice Code] | |
| Fax |  | | |
| DOB | ~[Date Of Birth] | | Gender: ~[Sex] | Ethnicity: ~[Ethnicity] | | | | |
| Physical/Communication difficulties (specify if any): | | | | | If interpreter required, state language: | | | |
| **CLINICAL INDICATION / PROBLEM / PROVISIONAL DIAGNOSIS**  *Please provide as much relevant clinical information as possible.*  *We see women who are considering a future pregnancy with complex medical conditions such as renal, cardiac, rheumatological and neurological disease and women with more general medical problems including:*   * *chronic hypertension* • *endocrine conditions* * *pre-eclampsia* • *respiratory disease* * *previous obstetric cholestasis* • *obesity* * *thyroid disorders* • *inflammatory bowel disease* * *diabetes* | | | | | | | | |
| **Clinical Detail (including relevant past medical history)** | | | | | | | | |
| **Allergies:**  ~[Allergies] | | | | | | | | |
| **Medication:**  ~[Medication] | | | | | | | | |
| Notes/documentation attached? Yes  No | | | | | | | | |
| Print name | | Referrer’s Signature: | | | | | | Date of request: ~[Today...] |
| Is the referrer a locum or registrar Y N | | | | | | | |  |