**Antenatal Self-Referral Form – Whipps Cross Hospital**

**Please send completed form to** **bhnt.wxantenatalreferrals@nhs.net**

**Date:** Click or tap to enter a date.

|  |  |
| --- | --- |
| **Patient Details** | **GP’s Details** |
| **Title:** | **GP’s name:** |
| **First Name:** | **Name and address of the GP surgery:**Post Code:Telephone: |
| **Surname:** |
| **Date Of Birth:** |
| **Address:**Postcode: |
| **NHS No (if known):**  | **Communication** |
| **Hospital No (if known):** | **Interpreter required:** Yes [ ]  No [ ] (family members/partners will not be used as interpreters)If YES, preferred language: |
| **Ethnicity:** Choose an item. |
| **Preferred title:** Choose an item. |
| **Mobile Phone:**Can we call you on this number? Yes [ ]  No [ ] If not, please provide an alternative contact number: |
| **Sight Problems:** Yes [ ]  No [ ]  |
|  **Email:** **Can we email you on this address?** Yes [ ]  No [ ]  | **Hearing loss:** Yes [ ]  No [ ]  |

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| **Clinical Information** |  | **Current Medical Condition** |
| **Start date of Last Menstrual Period (LMP):**(approximately if unsure) | Click or tap to enter a date. | **Do you have any of the following conditions (please tick):*** **Diabetes** Yes [ ]  No [ ]
* **High blood pressure**  Yes [ ]  No [ ]
* **Heart Condition** Yes [ ]  No [ ]
* **Epilepsy**  Yes [ ]  No [ ]
* **Sickle cell disease** Yes [ ]  No [ ]
* **Are you a sickle cell carrier**  Yes [ ]  No [ ]
* **Thalassaemia** Yes [ ]  No [ ]
* **Are you a thalassaemia carrier** Yes [ ]  No [ ]
* **Other** (Please specify)**:**

Click or tap here to enter text. |
| **Number of previous deliveries/ births:**  | Click here to enter text. |
| **Reasons if Booking after 12 weeks pregnant:**  | Click here to enter text. |
| **Have you had any pregnancies in the past?** Yes [ ]  No [ ] **If YES, how many?**  | Click or tap here to enter text. |
| **How many living children do you have?** |  |
| **Do you smoke?** **Are you or your partner currently taking non prescribed drug/ substances? Have you, your partner or one of your children ever had a social worker?**  | Yes [ ]  No [ ] Yes [ ]  No [ ] Yes [ ]  No [ ]  |
|  | **Current Medications** |
|  | **Drug/Dose:** Click or tap here to enter text. |
|  | **Are you Taking Folic Acid?** Yes [ ]  No [ ]  **Please ask your midwife about the “Healthy Start Vitamins” that are available for pregnant women, and if you are not currently taking Folic Acid discuss with your pharmacist as soon as possible.** |
| **Previous Obstetric (pregnancy) History** | **Medical / Surgical history** | **Other information** |
| Have you had any of the following conditions in your **previous** **pregnancies**: (Tick or delete )* **Caesarean Section**
* **Premature birth**
* **Stillbirth**
* **Low lying placenta**
* **Perineal trauma 3rd /4th degree tear**
* **Neonatal death**
* **Baby born with abnormalities**
* **Placenta accrete**
* **Other** (please specify): Click or tap here to enter text.
 | * **Diabetes**
* **High blood pressure**
* **Epilepsy**
* **Heart disease**
* **Kidney disease**
* **Liver disease**
* **Severe Asthma**
* **Blood Clotting Disorder**
* **Have you or your partner ever had depression, anxiety, or mental health issues**
* **Other Medical/Surgical problems:**
* **Click here to enter text.**
 | * **Domestic Abuse**
* **Learning Disability**
* **FGM**
* **Safeguarding concerns**

 **Social Worker: Choose an item.*** **Social Worker name if known: Click here to enter text.**
* **None of the above**
 |
|  | ***To be completed by the Hospital*****Dear Doctor / Midwife,** An Antenatal booking appointment has been booked with: Midwife / Team: Click or tap here to enter text.At (location) Click or tap here to enter text. A scan appointment has been booked on: (date) Click or tap to enter a date. At (time) Click or tap here to enter text. |