

Self Referral for Pregnancy Care

Personal Details

Name	Forename: Surname:	GP Name:
Address		Address
Telephone		Telephone
Date of Birth		
Interpreter Required	Yes <input type="checkbox"/> No <input type="checkbox"/> Language	Date of Referral
Ethnicity		
Marital Status	Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/>	

Current Pregnancy *(Items marked * are mandatory)*

Estimated Last Menstrual Period*	Estimated Delivery Date
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Past Obstetric History *(Note any previous caesarean section, assisted delivery, and pregnancy outcomes)*

No. of previous pregnancies:	Date and Place of previous Birth:	No. of miscarriages
No. of live children:		No. of pre-term babies: (Less than 37 weeks)
No. of terminations		

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)*

Heart Problems	Yes <input type="checkbox"/> No <input type="checkbox"/>	Neurological	Yes <input type="checkbox"/> No <input type="checkbox"/>
Lungs/Asthma/TB	Yes <input type="checkbox"/> No <input type="checkbox"/>	Diabetes	Yes <input type="checkbox"/> No <input type="checkbox"/>
Sickle Cell/Thalassaemia	Yes <input type="checkbox"/> No <input type="checkbox"/>	Kidney Problems	Yes <input type="checkbox"/> No <input type="checkbox"/>
High Blood Pressure	Yes <input type="checkbox"/> No <input type="checkbox"/>	Liver Problems	Yes <input type="checkbox"/> No <input type="checkbox"/>
Mental Health Problems	Yes <input type="checkbox"/> No <input type="checkbox"/>	Other	Yes <input type="checkbox"/> No <input type="checkbox"/>

Social History

(if answer is Yes to any of the following, please provide further details using the 'additional information' section)

Drug/alcohol misuse (including partner)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Any other mental health concerns	Yes <input type="checkbox"/> No <input type="checkbox"/>
Violence / domestic abuse	Yes <input type="checkbox"/> No <input type="checkbox"/>	Disability e.g. deaf/blind/physical handicap	Yes <input type="checkbox"/> No <input type="checkbox"/>
Child Protection Issues	Yes <input type="checkbox"/> No <input type="checkbox"/>	If smoked in last 6 months	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you have a social worker	Yes <input type="checkbox"/> No <input type="checkbox"/>		

Current Medication

Folic Acid: Yes No Vitamin D: Yes No Other:

Allergies:

Additional Information

For Hospital use only:

Date Booking Letter Received	/ /	Antenatal Clinic Appointment Date	/ /
Care Type: Midwifery Led / Obstetric Led	Low Risk <input type="checkbox"/> High Risk <input type="checkbox"/>		/ /

Please Return This Form to:

Antenatal Booking Co-ordinator, Antenatal Clinic, Northwick Park Hospital,
Watford Road, Harrow, Middlesex, HA1 3UJ

Telephone: 02088695252 Fax: 02088692880 Email: nlh-tr.antenatalbookings@nhs.net

Please send this form immediately. If possible before 10 weeks of pregnancy