SELF-REFERRAL FOR BOOKING INTO MATERNITY SERVICES
PATIENT DETAILS

Please complete ALL relevant fields. Failure to do so may slow down the process of making your first appointment. Women are routinely seen for their first appointment between 8 and 10 weeks (depending on the gestation when initial referral received).	
PERSONAL DETAILS	
Name:	**Date of Birth:**
Marital Status :	**Maiden Name (if applicable):**
Address:	**E-mail Address:**
Hospital number (if known):	**Is English your first language : YES/NO** **If you need help with Interpretation please let us know the language required:** (please note this will be a telephone consultation)
Home Telephone number:	**Mobile number:**
Please let us know of any dates you are unable to attend for your Booking Appt:	
Do you have a disability we need to be aware of when arranging your appointment: YES/NO	**If yes, please include details:**
Where have you lived in the last 12 months: UK / OUTSIDE UK (please circle as appropriate) **Can you show you have the right to live here? : YES/NO** (please circle as appropriate)	
GP name and address:	
CURRENT PREGNANCY	
1st day of last menstrual period:	**Estimated Due Date:**

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Have you had antenatal care elsewhere?: (please circle as appropriate) **YES/NO**	**If yes, where? (Name of Hospital/Country):**
Please inform us of any current issues relating to this pregnancy:	eg. Twins, IVF, Type 1 Diabetes
PREVIOUS PREGNANCIES	
Past obstetric history: Total no. of pregnancies (including miscarriages/termination): No. of Vaginal Births: No. of Ventouse/Forceps Births: No. of Caesarean Section: No. of Pre-term Births (before 37 weeks):	Any other issues (eg. Assisted fertility, pre-eclampsia (PET), Obstetric Cholestasis (ICP), Gestational Diabetes):
MEDICAL HISTORY	
Medical and mental health history: Cardiac (heart) YES/NO High blood pressure: YES/NO Sickle cell/Thalassaemia: YES/NO Diabetes: YES/NO Renal (Kidney): YES/NO Liver Disease: YES/NO Haematology (blood): YES/NO Thyroid: YES/NO Neurological (brain): YES/NO Respiratory(asthma): YES/NO Mental Health problems: YES/NO	If yes to any of these, please provide brief details including any medication taken:

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SOCIAL/RISK FACTORS		
Do you have a Social Worker?:	YES/NO	If yes to any of these, please provide brief details:
Child Protection concerns:	YES/NO	
Alcohol Misuse:	YES/NO	
Domestic Abuse:	YES/NO	
Substance Misuse:	YES/NO	
Learning Difficulties:	YES/NO	