Appendix 3

Salisbury Maternity Unit Transfer form

To be completed when a woman requires transfer to another service provider:

Name:	**DOB:**	**Hospital Number:**	**Address:**
COMM MW:	**GP:**	**Consultant:**	

Gravida:	Para:	Gestation:	Blood group:
Antenatal risk factors: Psychological Low /High	Medical Low /High	Social Low/high	If risk factors have been identified please provide details:
Antenatal VTE risk assessment: Low /	Intermediate /	High	Is Prophylactic LMWH given If so give details of date and time of last dose:

Antenatal complications and relevant Obstetric History:
Intrapartum Complications:

Date of delivery:	Time of delivery:	Mode of delivery: (if instrumental or LSCS please provide details:)
If LSCS, please state material used to close the skin:		
3rd stage:		
Placenta complete/ incomplete	Membranes complete/ incomplete	
Perineum:		

Postnatal VTE risk assessment: Low / Intermediate / High	Is Prophylactic LMWH given If so give details of date and time of last dose:
Management plan:	
Postnatal Complications:	Postnatal Anti D given: Yes/No Date: Dose:

Current medication:		
Name of drug	Frequency and duration of course	Date and Time of last dose:

Baby's details		
Name:	Weight:	Apgar /1 /5 /10
Method of feeding: BF/ AF/ expressing		

Name of midwife	Signature:	Date: