Teenage Pregnancy Yes ❑ No ❑
Booking information leaflets given Yes ❑ No ❑
Pregnancy book offered/accepted Yes ❑ No ❑
Medical/social high risk referral to SOM Named on form Yes ❑ No ❑
English language issues: No ❑ Speaks: Little ❑ None ❑
Reads: Little ❑ None ❑
Understands Little ❑ None ❑

Interpreter needed Yes ❑ No ❑

Medical	**Social**	**Referred to:**
LOW	LOW	.....
HIGH	LOW	.....
LOW	HIGH	.....
HIGH	HIGH	.....

Screening Choices Consent Yes ❑ No ❑

Screening discussed ❑
Dating Scan Only ❑
Down's syndrome screening ❑
20 Week Anomaly Scan ❑
Screening consent checked and signed ❑
FOQ and first trimester form ❑

Risk Assessment Complete

Scan Only ❑
Cons App & Scan ❑

Reason for Referral / GP assessment: .....

.....

.....

.....

Copy of referral sent to health visitor ❑ Date Copy Sent to HV: _ _ / _ _ / _ _

Seen and Signed by A/N Clinic Co-ordinator: .....

Print Name: .....

Seen and Signed - Sonographer: .....

lgd OF01827 07/04 SAL039

1st Point of Contact: MW / GP / Other .....
NHS No: .....
Gest at Booking: .....
Choice of Trust for Birth: .....
Booked Elsewhere Previously (This Pregnancy).....
Reason For Change.....

Salisbury NHS
NHS Foundation Trust

MATERNITY SERVICES
COMMUNITY MIDWIFE REFERRAL LETTER IN CONFIDENCE

Dear Antenatal Co-ordinator	*Date of booking interview _ _ / _ _ / _ _*
	Date received O&G reception, SDH _ _ / _ _ / _ _
Location of booking	*Consultant* .....

Patient's name:	**Maiden name:**
Address:	
Post code:	
Telephone number:	
Date of birth: _ _ / _ _ / _ _ (___ age at delivery)	**Religion:**
General Practitioner:	
G.P. address:	
Occupation:	Ethnic Group:
Married ☐ Single ☐ Divorced ☐ Defacto ☐ Widow ☐	

Partner:	D.o.B	Telephone No:
Occupation:	Relationship	
Next of Kin		Partner Ethnic Group:
Blood relative to partner: Yes / No	Address:	

Pregnancy and booking interview details:

Gravida:	**Parity:**
LMP:	**EDD:**
Accurate LMP date? Yes ☐ No ☐	
Was LMP normal? Yes ☐ No ☐	
Menstrual cycle _ _ / _ _	**Fertility treatment needed Yes / No**

Previous pregnancy/pregnancies:

Date	**Place**	**Gestation**	**Antenatal**	**Labour** Spont/IOL Duration/Mode	**Puerperium**	**Infant** M/F Wt

A community booking interview has taken place and the patient is now in possession of her maternity records.

Signature of Midwife: *Signature of Client:*

Named Midwife: *Midwifery Team*

Previous obstetric history — Details

Retained placenta	
Severe perineal trauma	
Previous LSCS	
Haemorrhage	
Previous poor outcome	
Hypertension/ Pre eclampsia	
Blood antibodies	
Previous TOP for medical reasons.	
Group B Strep.	
Booking BIP	

Date of last cervical smear. Was a follow up required?	
Oral contraceptive Yes / No	Date last taken
Is this pregnancy planned	Yes / No

Pre existing medical problems.	Details including medication
Cardiovascular/Hypertension	
Haematological problems / Thromboembolic disorders	
Respiratory	
Autoimmune/Infectious/HIV/HepB/Hepatic	Anti TNF drugs Yes ☐ No ☐
Urinary / Renal	
Gastrointestinal	
Endocrine	
Neurological	
Muscular-skeletal - including fractures	
Gynaecological including STIs or fertility treatment (not LSCS)	
General surgery	
Known Allergies	
Anaesthetic problems	
Blood Transfusions (enter year)	

Current medication	

Psychological health — Details

History of mental health problem	
Treatment given	
Hospitalisation for mental health problem	
Family history of mental health problem.	

Any other medical concerns or impairments

e.g. Age 40 or over or Malignant disease.

Health issues

Folic acid Pre-conception Dosage	
Vitamin D Supplements (Recommended 10mcg daily)	
Type of diet	
Booking weight, Height & / BMI	
Chicken pox	
Rubella Vaccinated Exposure	
Sight problems prior to age 12.	
Hearing	
Consent for blood products Yes ☐ No ☐	
Medical Assessment previously in the UK Yes ☐ No ☐	
Female Genital Mutilation Yes ☐ No ☐	

Social history / Other Impairments

Have you ever smoked?		
Do you smoke? Now Yes No	Partner Yes ☐ No ☐	
Do you want to quit?		
Do you want to be referred?		
Smoking now. Number per day		
Smoke Stop referral done	CO_3 reading =	
Previous/current drug use		
Alcohol intake. Units per week.	Before pregnancy:	At booking:
Are there any housing issues?		
Do you feel this patient is an unsupported parent?		
Is there current or former Social Services involvement for Child protection and / or known domestic issues?		
Name of Social Worker		
If former involvement with Social Care surnames of children		
Needs a C.A.F. Yes ☐ No ☐	C.A.F. in existance Yes ☐ No ☐	

FAMILY HISTORY	PATIENT	CHILDREN	PARENTS	SIBLINGS	PARTNER	PARENTS	SIBLINGS
Clotting disorder / DVT							
Multiple birth							
Hepatitis							
DDH							
Kidney disorders							
Congenital anomaly							
Deafness							
Haemaglobinopathy							
Hypertension / Cardiac							
Diabetes							
Tuberculosis							
Genetic problems							
Asthma							
Eczema							
SIDS							