

North Central London Maternity Services Referral Form

DATE OF REFERRAL:

Please ✓ the corresponding box for the hospital the referral is being made to:

<p><u>Barnet & Chase Farm</u> Fax: 020 8216 5136 Tel: 020 8216 5137 antenatal@bcf.nhs.uk</p>	<p><u>Edgware Birth Centre</u> Fax: 020 8732 6773 Tel: 020 8732 6777/6669 birthcentre.ech@bcf.nhs.uk</p>	<p><u>North Middlesex</u> Fax: 020 8887 2934 Tel: 020 8887 2000 # 3055</p>
<p><u>Royal Free</u> Fax: 020 7830 2752 Tel: 020 7794 0500 # 36169</p>	<p><u>UCLH</u> Fax: 020 7380 9754 Tel: 020 7380 9400 antenatalclinic@uclh.nhs.uk</p>	<p><u>Whittington</u> Fax: 020 7288 5576 Tel: 020 7288 5586 Whh-tr.maternityreferrals@nhs.net</p>

<p>Urgent: Yes / No Specify:</p>
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<p>Office Use Only <input type="checkbox"/> Urgent <input type="checkbox"/> Routine <input type="checkbox"/> High Risk <input type="checkbox"/> Low Risk</p>

PLEASE ANSWER ALL QUESTIONS IN BLOCK CAPITALS

Surname:		Title: Mrs/ Miss/ Ms/ Other	
First Name:		Date of Birth:	Age:
All previous surnames:		NHS number:	
Address:		Details of GP: (name, address, telephone and fax)	
Post Code:			
Preferred contact tel no:			
Ethnicity:		Interpreter required: yes / no	
		Language:	
Name and details of referrer if not GP:		Signature:	
LMP:	EDD:	Gestation (Wks):	
Past Obstetric history:		Current medication:	
Past Gynaecological History:		Allergies:	
Past Medical and Surgical History:		Significant family history:	
Significant psychological history:		Social concerns and details of social worker if applicable:	

Other comments <u>(include letter if needed)</u> :		
MEDICAL RISK ASSESSMENTS		
Auscultation Heart:		Auscultation Lungs:
Weight (Kg):	Height (cm):	BMI:
Alcohol History:		Smoking history:
BP:		Urine (protein and glucose):

The patient should be offered an appointment at the latest by 12/40 or within 2 weeks, if they are referred after 12/40.