Western Sussex Hospitals NHS
NHS Foundation Trust

Antenatal Referral Form

Patient Details	
Name:	Date of Birth:
Address:	NHS Number: Hospital Number:
Daytime Telephone: Work Telephone Mobile Telephone:	Country of origin Religion Relationship

GP Details	
GP Name:	Telephone Number:
Practice:	Fax Number: **Date of Referral:** **Referred to: Worthing Hospital** ☐ **St Richards Hospital Chichester** ☐
Next of kin: Contact details:	

LMP:

Your patient will be booked for midwifery led care unless one or more risk factors are present (see attached page). **Please fill in the boxes below and add relevant details to ensure the patient is referred to the appropriate consultant led clinic.** Referrals will be generic unless specified for a particular reason

- ☐ Age <18 or >40 — Please state **Age:**
- ☐ BMI <18 or >35: Please weigh today: height _____ weight_____ **BMI:**
- ☐ Parity: Specify no. of livebirths: _____ stillbirths:_____miscarriages: _____terminations _____.

Current Medication

BP:

CVS:

Relevant PMH

Chest:

Additional Information (e.g. social H)

Please state if you are attaching a computer printout of this information: Yes / No
Or additional referral letter: Yes / No

Past Obstetric History

Relevant Past Gynaecological History

Please fax this form to the site referred to: Antenatal clinic 01243 831658 (Chichester) or Antenatal clinic 01903 285218 (Worthing)

Hospital use only	
Date & time referral received: / / Date & Time of Appointment: / / @:	**Referred by**: