Kingston Hospital NHS
NHS Foundation Trust

Fax to 02089343573

E-mail to khn-tr.maternityreferrals@nhs.net

MATERNITY SELF- REFERRAL FORM (* is a Mandatory field)

When completing please ensure that all mandatory fields are completed and that you provide us with your contact details.

It is particularly important that we have a date of your last menstrual period (LMP) as this is used to calculate your Estimated Delivery Date (EDD) and ensures we schedule appointments at right times.

Please allow 10 working days for us to process your form, after which you should receive your booking and scan appointment date and a pack of information by post.

If you have any queries regarding your referral please contact the ante natal clinic on 0208 546 7711 ext 2435.

Please note that this form will be sent via an open internet connection even though it will be delivered to a secure email address – khn-tr.maternityreferrals@nhs.net.

This document is in Read Only format. Please enter your details and save the document to your local drive using the Save As option. Please then send as an attachment to the above email address.

Date*

Your Personal Details*

Title:		NHS Number:	
Surname:		First Name:	
Maiden Name:		Date of Birth:	
Age:		Marital Status:	
First language:		Translator required Y/N:	

Obstetric History

Date	Place (name location)	Type of Delivery	Weeks Gestation	Sex of Baby	Baby's Weight	Complications?
What date did your last menstrual period start?						
What is your Estimated Date of Delivery (EDD)?						

Obstetric & Gynaecological History Please provide any significant details:

Past Medical / Surgical History Please provide any significant details:

Mental Health History Please provide any significant details:

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Social History Please tell us everything about your social history that you think would be useful or relevant (domestic violence, smoking, alcohol/ drug addiction etc.)?
Family History Please tell us about any history of illness in your family:
Midwife/Clinician preference. Tell us if you prefer to see a particular midwife/clinician (please name):

Your Contact Details*

Surname:		Tel.No:	
Address:			
Postcode:		Mobile No:	
Email:			

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Your GP Details*

GP Name:		Tel.No:	
Address:		Fax No:	
Postcode:		Email:	

For Office Use:

Referral date:

Date received:

Accepted: Y / N

Refused: Y / N

If yes – please include reason for refusal:

Date of booking appointment:

Date of scan appointment: