**Little Havens antenatal referral form**

Pregnant person’s details:

|  |  |  |  |
| --- | --- | --- | --- |
| Full name: |  | Known as: |  |
| Date of birth: |  | NHS number: |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Gender Identity: | Male: | Female: | Non-binary: | Other: |
| Religion/ beliefs: |  | | Preferred Pronouns: |  |

|  |  |
| --- | --- |
| Home Address: |  |
|  |
|  |
| Postcode: |  |
| Telephone numbers: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| First language(s) and or preferred method of communication: |  | Interpreter required: | Yes  No |
|  |

Consent:

|  |
| --- |
| Please confirm that the pregnant person has consented to the referral? Yes  Does the pregnant person agree to share their health electronic care record? (*This help Little Havens to review the most up to date clinical information about the pregnant person*) Yes  No |

Referrer’s details:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Name: |  | | Email: | |  | |
| Relationship to person: | |  | | Date of referral: | |  |
| **Please complete the following sections if you are a healthcare professional:** | | | | | | |
| Job title |  | | Organisation: | |  | |
| Telephone numbers: |  | | Email: | |  | |

Partner’s details:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Name: |  | | Same address? | | Yes |  | |
| No |  | |
| Address  if different: |  | | | | | | |
| Telephone: |  | | | | | | |
| Email: |  | | | | | | |
| Gender Identity: | Male: | Female: | | Non-binary: | | | Other: |
| Preferred Pronouns: |  | | | | | |
| Do they have a disability? | |  | | | | | |
| Ethnic group: | |  | | | | | |
| Main language(s): | |  | | | | | |
| Interpreter required? | | | | | Yes |  | |
| No |  | |
| Do they read English? | | | | | Yes |  | |
| No |  | |
| If not, how do they communicate? | |  | | | | | |

Diagnosis:

|  |  |
| --- | --- |
| What is the antenatal diagnosis/diagnoses? |  |
| If applicable - date of diagnosis: |  |
| Expected Date of Delivery: |  |

|  |  |
| --- | --- |
| Who or what prompted you to make this referral to Little Havens? |  |

|  |
| --- |
| Please include further information you feel may be helpful, e.g. previous maternal history; clinic letters; copy of antenatal Advance Care Plan (ACP) etc. |
|  |
| What is the expected prognosis of the unborn baby? |
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| --- |
| Urgency of support required – please check one box below |
| Non-urgent  Urgent  Unknown  **Please telephone us if you require an urgent response (01702 552 200)** |

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| --- |
| Have any ante-natal advance care planning discussions taken place? If yes, please attach / include documentation.  Is there a resuscitation/ReSPECT plan in place? Yes  No |

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| --- | --- | --- | --- | --- | --- |
| Are there any safeguarding concerns with the pregnant person or other members of the household? | Yes |  |  | If yes, please give brief outline |  |
| No |  |

Children (and other household family members):

| Relationship  to pregnant person (e.g. full, half step): | Name: | Gender Identity: | DOB: | DOD: | Do they have the same condition (Y/N) | Please specify if language ethnicity or religion are different? |
| --- | --- | --- | --- | --- | --- | --- |
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Additional information such as any relevant current family circumstances:

|  |
| --- |
|  |

Professionals involved with the pregnant person:

**General Practitioner**

|  |  |  |  |
| --- | --- | --- | --- |
| GP Name: |  | Telephone: |  |
| Address: |  | Postcode: |  |

**Medical Professionals:**  *please complete for obstetrician, neonatologist, midwife etc involved with pregnant person.*

| Name | Hospital / Medical Community | Speciality | Telephone number | Email |
| --- | --- | --- | --- | --- |
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**Please return this completed form via our website here** [**www.havenshospices.org.uk/refer/refer-a-child-to-little-havens/**](http://www.havenshospices.org.uk/refer/refer-a-child-to-little-havens/)