Pregnancy Self Referral Form

Please complete all sections of this form

Following completion of this form please call 01603 481222 to book an appointment with a Community Midwife. If you are less than 6 weeks pregnant please do this when you are between 6 – 8 weeks. If you are more than 8 weeks pregnant now please do this on the next working day.

If you have Type 1 or Type 2 diabetes please ring Antenatal Clinic on 01603 286795, Monday to Friday 8:30am – 5pm where an appointment for the next clinic can be made for you, once you have completed the form.

First Name (required)
Surname (required)
Previous Name
Date of Birth (required)
Age
Hospital No/MRN (if known)
NHS Number (if known)

Address (required)
Postcode (required)
Email
Daytime contact Number (required)
Mobile Number
May we contact you on this mobile number by text message?
YesNo

Marital Status
Religion
Ethnic Group
White - BritishWhite - IrishWhite - Any Other BackgroundMixed White & Black CaribbeanMixed White & Black AfricanMixed White & AsianMixed - Any Other BackgroundAsian or Asian British IndianAsian or Asian British PakistaniAsian or Asian British BangladeshiAsian - Any Other BackgroundBlack or Black British CaribbeanBlack or Black British AfricanBlack - Any Other BackgroundOther Ethnic Group - ChineseAny Other Ethnic GroupNot StatedNot Known

GP Name
GP Surgery (required)

GP Address & Postcode

Next of Kin Name (required)
Next of Kin Relationship (required)
Next of Kin Address (required)
Next of Kin Contact Number (required)

Have you lived in the UK for the last 12 months (required)
YesNo

If No, previous country of residence
Nationality (required)

Do you require an interpreter?
YesNo
If yes, language spoken?

Do you have a non-UK European Health Insurance card? (required)
YesNo
Please tell us about the purpose of your stay in the UK (check all that apply if applicable)
Holiday/visit friends or familyOn businessTo live here permanentlyTo workTo studyTo seek asylumOther
First day of your last menstrual period (LMP)? (required) - if not known please enter 'Unsure'

Have you had a scan? (required)
YesNo
Date scan was completed

Do you have any communication needs e.g. hearing loss, visual impairment or learning disability? (required)
YesNo
If yes please give details

DECLARATION (required)

I have read & understood the reasons I have been asked to complete this form
I agree to be contacted by the Trust to confirm any details I have provided

It is my request to use email/text messaging for the purposes of my ongoing patient care within the Norfolk & Norwich NHS Trust (NNUH)

I accept that neither this form, email or text message are a totally secure system for sending nor receiving information and that the NNUH has no responsibility for my information once it leaves an authorised NHS network at my request

The information I have given on this form is correct to the best of my knowledge
I understand that information will be shared with other relevant care providers if necessary

I accept that my information (not identifying me as an individual) may be:
Shared with other organisations (non clinical data) Yes/No
Used for Service Evaluation / Improvement Yes/No
Used for Research Yes/No

If we need to share data that identifies you we will seek your permission first.

Please refer to the Privacy Notice on this website for further information.