

**Self-Referral for Maternity Care**

As soon as you have a positive pregnancy test you can self-refer for maternity care

Please complete this form and upon receipt the Midwives will arrange your first booking appointment.

**You must order a prescription from your GP for the following:**

* **Folic acid = 400micrograms per day.** NOTE - YOU WILL NEED TO SEE YOUR GP IF THERE IS A FAMILY HISTORY OF SPINA BIFIDA OR YOUR BMI IS >30 AS THE DOSE WILL BE HIGHER
* **Vitamin D = 10 micrograms per day**

**Alternatively** you can buy a suitable pregnancy multivitamin that contains both Folic acid and Vitamin D. If you have not already started this medication, it is very important that you start as soon as possible and continue for at least the first 12 weeks of your pregnancy.

You will receive a letter in the post for your booking appointment, which will be between 12-14weeks of pregnancy. If you have not received an appointment by the 12th week of your pregnancy please contact Craigavon Area Hospital (CAH) Tel: 028 3756 1812 or Daisy Hill Hospital (DHH) Tel: 028 3756 3024

*For Yes/No responses add X*

**Self-Referral for Maternity Care Form
*Please ensure ALL details are accurate to ensure a smooth and timely referral to maternity services***

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| --- | --- | --- | --- |
| Title: |  | Forenames in full: |  |
| Surname  |  | Date of Birth |  |
| Address including postcode |  |
| Health and care number |  | Email |  |
| Home Tel No |  | Mobile Tel No |  |
| Can we contact you via text/email message  | Yes |  | No |  |
| Hospital you wish to have you referral directed to:  | Craigavon Area Hospital  |  | Daisy Hill Hospital, Newry |  |
| Marital status |  | Nationality |
| Ethnic group |  | Interpreter required  | Yes  |  | No |  |
| Language spoken |  | First day of last menstrual period or best estimate |
| Your occupation  |  | Your partners occupation |  |
| GP – Name/Address/Postcode |  |
| Your weight | Your Height | Your BMI | Do you smoke? |
|  |  |  | Yes  |  | No |  |
| First day of last menstrual period or best estimate: |  | Number of previous pregnancies  |  |
| Type of birth and number of each | Normal |  | Vacuum |  | Forceps |  | Caesarean section |  | Miscarriage |  |
| Detail any problems with previous pregnancies during the antenatal period, labour or postnatal period if applicable. |
|  |
| Please provide details of any medical conditions you have. Include details of any prescribed medications**(IF YOU ARE ON PRESCRIBED MEDICATION PLEASE CONTACT YOUR GP AS SOON AS POSSIBLE)** |
|  |
| If you have any queries please contactCraigavon Area Hospital Tel: 028 3756 1812 or Daisy Hill Hospital Tel: 028 3756 3024**This form when completed must be emailed to** **Antenatal.midwives@southerntrust.hscni.net** |