**Are you newly pregnant and wish to contact your midwife?**

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

Please complete this form and upon receipt of it midwives will arrange the first booking appointment for you.

**You will also need to order a prescription from your GP for the following:-**

• **Folic acid = 400micrograms per day**. (NB. 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 of these. 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.**

It is important to ensure **ALL** details are accurate to allow a smooth and timely referral to maternity services.

**Please ensure your address and telephone numbers are up to date with your GP.**

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 **(028)37561812 for CAH** or **(028)37563024 for DHH**

Please e-mail your completed form to [Antenatal.midwives@southerntrust.hscni.net](mailto:Antenatal.midwives@southerntrust.hscni.net) for CAH & DHH indicating your preference.

**Which hospital do you wish to have your referral directed to?**

Craigavon Area Hospital Daisy Hill Hospital

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Title:-** | | **Forename:-** | | | | **Surname:-** | | |
| **Date of birth:-** | | | | **Health and care number:-** | | | | |
| **Address (including postcode):-** | | | | **Mobile number:-** | | | | |
| **Landline number:-** | | | | |
| **Email address:-** | | | | |
| **Nationality:-** | | | | **Interpreter required:- NO YES**    **Language\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | |
| **GP name and address:-** | | | | | **Weight\_\_\_\_\_\_\_\_\_\_\_\_**  **Height\_\_\_\_\_\_\_\_\_\_\_\_**  **BMI\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Do you smoke? Yes**  **No** | | | |
| **First day of last menstrual period or best estimate:-** | | | | | **Number of previous pregnancies:-** | | | |
| **Type of birth and number:-** | **NORMAL** | | **VACUUM** | | **FORCEPS** | | **CAESAREAN SECTION** | **MISCARRIAGE** |
| Please 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. Please include details of any prescribed medications **(IF YOU ARE ON PRESCRIBED MEDICATION PLEASE CONTACT YOUR GP AS SOON AS POSSIBLE)** | | | | | | | | |