**Maternal Healthy Lifestyle Salford Referral Form**

*By summiting this form, you are confirming that the patient has consented to a referral being made and they are aware that completion of this form indicates consent to their information being shared with MoreLife.*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Patient demographics** | | | | | |
| **Full name (including surname):** |  | | | | |
| **Address and postcode:** |  | | | | |
| **Date of birth:** |  | | | | |
| **Gender:** | Choose an item. | | |  | |
| **Sexual Orientation:** | Choose an item. | | |  | |
| **NHS number:** |  | | | | |
| **Contact number:** |  | | | | |
| **Email address:** |  | | | | |
| **Ethnicity & religion** (as per the pregnancy notes) | | | | | |
| **Faith/ Religion** | Choose an item. | | |  | |
| **Ethnic Origin** | Choose an item. | | | | |
| **Communication** | | | | | |
| **Patients preferred language?** |  | | | | |
| **Does the patient speak English?** | **Yes** |  | **No** | |  |
| **Does the patient require an interpreter?** | **Yes** |  | **No** | |  |
| **Any other communication needs?** |  | | | | |
| **Primary Care Contact Information** | | | | | |
| **GP practice name** |  | | | | |
| **GP practice address** |  | | | | |
| **GP practice telephone** *(if known)* |  | | | | |
| **Pregnancy Information** | | | | | |
| **Estimated due date?** |  | | | | |
| **Is this a first pregnancy?** | **Yes** |  | **No** | |  |
| **Is this a multiple pregnancy (twins or more)?** |  | | | | |
| **Weight at booking appointment:** |  | | | | |
| **Height at booking appointment:** |  | | | | |
| **Body Mass Index (BMI)** |  | | | | |
| **Medical History** | | | | | |
| **Does the patient have a disability?** | **Yes** |  | **No** | |  |
| **If yes to the above, please provide details** | Choose an item. | |  | | |
| **Does the patient have diabetes (including gestational diabetes)?** | **Yes** |  | **No** | |  |
| **If yes to the above question, please confirm the diabetes diagnosis** |  | | | | |
| **Does the patient have any other medical history we need to be aware of?** *\* a care summary record will be requested from the GP* |  | | | | |
| **Contact Information of referrer** | | | | | |
| **Name:** |  | | | | |
| **Profession:** |  | | | | |
| **Work address:** |  | | | | |
| **Contact number:** |  | | | | |

Completed referrals to be returned to: [morelife.gm.sawm@nhs.net](mailto:morelife.gm.sawm@nhs.net)