rainbows
Brightening short lives

Antenatal Care Referral Form

Mother's Details		
Surname:	First Name(s):	
EDD:		Date Of Birth:
NHS Number:		
Home Address:		
Postcode:	Telephone:	
Mobile:	Email:	
Religion:		
First Language:	Interpreter Required?	
Any Health Needs:		
Booking Hospital:		
Intended Place Of Delivery:		
Foetal Diagnosis And Prognosis:		
Name And Gender (If Known):		M ☐ F ☐

Ethnic Group	
White	☐ English/Welsh/Scottish/Northern Irish/British Irish ☐ Gypsy Or Irish Traveller ☐ Any Other White Background: __________
Mixed Multiple Ethnic Groups	☐ White And Black Caribbean ☐ White And Black African ☐ White And Asian ☐ Any Other Mixed/Multiple Ethic Background: __________
Asian Or Asian British	☐ Indian ☐ Pakistani ☐ Bangladeshi ☐ Chinese ☐ Any Other Asian background: __________
Black/African/Caribbean/ Black British	☐ African ☐ Caribbean ☐ Any Other Black, African, Caribbean Background: __________
Other Ethnic Groups	☐ Arab ☐ Any Other Ethic Group: __________

Parent Two Details	Parental Responsibility? (Please Tick) ☐
Name:	
Date of Birth:	Email:
Telephone:	Mobile:
Address (If Different To Above):	
	Postcode:
Religion:	
First Language:	Interpreter Required?
Any Health Needs?	

Does This Family Currently Receive Care/Support From Another Children's Hospice?

☐ Yes ☐ No

If Yes, Please Indicate Whom And The Date Referred:

Siblings

Name:	M/F	D.O.B.	Relationship*	Health needs
1.				
2.				
3.				
4.				
5.				
Nursery/School:				

*Full/Half/Adopted/Step

Professional involvement

General Practitioner (GP):	
Hospital:	
Email:	Phone:
Obstetrician:	
Hospital:	
Email:	Phone:

Professional involvement (Continued)	
Neonatologist:	
Hospital:	
Email:	Phone:
Foetal Medicine Consultant:	
Hospital:	
Email:	Phone:
Community Midwife:	
Hospital:	
Email:	Phone:
Antenatal Screener:	
Hospital:	
Email:	Phone:
Health Visitor:	
Hospital:	
Email:	Phone:

Professional involvement (Continued)	
Other:	
Hospital:	
Email:	Phone:
Other:	
Hospital:	
Email:	Phone:

Full Obstetric Background (Enclose Scan Results And Any Relevant Letters)
Number Of Previous Pregnancies:
Number Of Live Children:
Previous Pregnancy Complications If Relevant:

Full Obstetric Background (Continued)

Previous Delivery Complications If Relevant:

Previous Postnatal Complications If Relevant:

Current Pregnancy History

Mandatory - Please Fill In The Sections On This Page

Are The Family Currently Accessing A Counselling Service?	Yes ☐ No ☐
Details If Yes:	
Is Any Family Member Subject To Any Safeguarding Plans?	Yes ☐ No ☐
Any Addition Information (Please Include Name Of Social Worker?)	
Is There Any Specific Type Of Support The Parents Would Like From Rainbows?	

Are There Any Known Risks Within The Family's Home Environment To Help The Hospice Team In Their Risk Assessments (For Example, Planning Home Visits)?

Consent

Rainbows will use the information provided on this form in order to process the referral, and determine how best we can support the child and family. Information will also be used to ensure we are providing the safest and most effective support for the child and family. Information will be securely held on our systems and only be held for as long as we have a legitimate reason for it.

In order to ensure that we have access to the most accurate treatment and medical information, does the mother give consent to contact the relevant professionals involved in the care of her pregnancy and postnatally?

Information collected will only be used by Rainbows for the purposes of providing care, support and treatment. These preferences for contact can be discussed and reviewed with the hospice directly.

☐ Yes ☐ No

Referrer	
Name:	
Job Title:	
Phone:	
Email:	
Signature:	Date:

Please return the completed form to **referrals@rainbows.co.uk**