

Antenatal Care Referral Form

Mother's Details

Surname:

Forename(s):

EDD:

Date of Birth:

NHS Number:

Religion:

Ethnicity:

Mobile:

Telephone:

Address (Including Postcode):

Email:

First Language:

Interpreter Required?:

Yes

No

Any Health Needs:

Booking Hospital:

Intended Place of Delivery:

Foetal Diagnosis and Prognosis:

Name and Gender (If Known):

Male

Female

Parent Two Details

Surname:	Forename(s):
Date of Birth:	Religion:
Ethnicity:	Mobile:
Telephone:	
Address <i>(If Different To Above):</i>	
Email:	
First Language:	
Interpreter Required?:	Yes No
Any Health Needs:	

Siblings

Name	Gender	D.O.B.	Relationship*	Health Needs	Nursery/ School
1.					
2.					
3.					
4.					

**Full/Half/Adopted/Step*

Professional Involvement

General Practitioner (GP):	
Hospital:	
Mobile:	Telephone:
Email:	



Obstetrician:

Hospital:

Mobile:

Telephone:

Email:

Neonatologist:

Hospital:

Mobile:

Telephone:

Email:

Foetal Medicine Consultant:

Hospital:

Mobile:

Telephone:

Email:

Community Midwife:

Hospital:

Mobile:

Telephone:

Email:

Antenatal Screener:

Hospital:

Mobile:

Telephone:

Email:

Health Visitor:

Hospital:

Mobile:

Telephone:

Email:



Full Obstetric Background (Enclose Scan Results And Any Relevant Letters)

Number of Previous Pregnancies:

Number of Live Children:

Previous Pregnancy Complications *(If Relevant)*:

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

Is Any Family Member Subject To Any Safeguarding Plans?

Yes

No

Any Additional 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 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 will only be held for as long as we have a legitimate reason for it.

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 contact preferences can be discussed and reviewed directly with the hospice.

Yes

No

Memories In Heartbeat Criteria: Any baby expected to die during pregnancy, at delivery, or shortly after birth due to a life-limiting condition should have a good-quality, one-minute heartbeat recording obtained during a foetal scan using voice notes.

If you think the baby meets the criteria, please email your local Rainbows Clinical Nurse Specialists:

- QMC - elisa.monk@rainbows.co.uk
- LRI - clementine.ashcroft@rainbows.co.uk
- ACP - jane.lewins@rainbows.co.uk

They will complete a referral on SystemOne on your behalf. Please obtain consent from the family to access their S1 records and record data on there, which is shared with other Community Teams.

Please make the family aware that they will be contacted by Rainbows Music Therapist to discuss.

Referrer

By signing the Referral Form, you are confirming this referral has been consented to by the family.

Name:

Job Title:

Organisation:

Address (Including Postcode):

Mobile:

Telephone:

Email:

Date:

Signature:

Additional Information Relevant for Referral:

Submit Form



rainbows.co.uk

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Registered Office: Lark Rise, Loughborough, Leicestershire LE11 2HS.