**Pregnant Person’s details:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Surname: |  | Forename(s): |  | Known as: |  |
| Date of Birth: |  | NHS Number: |  |  |
| Gender Identity | Male: [ ]  | Female: [ ]  | Non-binary: [ ]  | Other: [ ]  |
| Preferred Pronouns: |
| Religion/beliefs |  |
| Home Address: |  |
|  |
|  |
| Postcode: |  |
| Telephone numbers: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| First language(s) and or preferred method of communication: |  | Interpreter required: | Yes [ ]  No [ ]  |
|  |

**Consent:**

|  |
| --- |
| Please confirm that the pregnant person has consented to the referral? Yes [ ]  No [ ]  N/A [ ] Does the pregnant person agree to share their health electronic care record? (this helps EACH to review the most up to date clinical information about the pregnant person. )Yes [ ]  No [ ]  |

|  |
| --- |
| **Partner’s Details** |
| Name: |  | Same address? | Yes | [ ]  |
| No | [ ]  |
| Address if different: |  |
| Telephone: |  | Email: |  |
| Gender Identity | Male: [ ]  | Female: [ ]  | Non-binary: [ ]  | Other: [ ]  |
| Preferred Pronouns: |
| Do they have a disability? |  |
| Ethnic group: |  |
| Main language(s): |  |
| Interpreter required? | No | [ ]  |
| Yes | [ ]  |
| Do they read English? | Yes | [ ]  |
| No | [ ]  |
| If not, how do they communicate? |  |

**Please note:**

**As the referrer you are responsible for ensuring that relevant clinical information is provided to help with prompt decision making about eligibility for EACH services and the avoidance of any delay**

**Diagnosis:**

|  |  |
| --- | --- |
| What is the antenatal diagnosis/diagnoses? |  |
| Date of diagnosis/diagnoses: |  |
| Expected Date of Delivery |  |

|  |  |
| --- | --- |
| Please include further information you feel may be helpful, e.g. previous maternal history; clinic letters; copy of antenatal Advance Care Plan (ACP) etc. |  |

|  |  |
| --- | --- |
| Who or what prompted you to make this referral to EACH?  |  |

|  |  |
| --- | --- |
| What is the expected prognosis of the unborn baby?  |  |

|  |
| --- |
| Urgency of support required – please check one box below |
|  [ ]  Non-urgent [ ]  Urgent [ ]  Unknown**Please telephone us if you require an urgent response (0808 196 9495)**   |

|  |
| --- |
| Have any ante-natal advance care planning discussions taken place? If yes, please attach / include documentation. Is there a resuscitation/ReSPECT plan for the baby in place? Yes [ ]  No [ ]   |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Are there any safeguarding concerns with the pregnant person or members of the household? |  | Yes | [ ]  |  | If yes please give brief outline |  |
|  | No | [ ]  |

**Children (and other household family members):**

| Relationship to pregnant person (e.g. full, half step): | Child name: | Gender Identity: | DOB: | DOD: | Do they have the same condition (Y/N) | Please specify if language ethnicity or religion are different? |
| --- | --- | --- | --- | --- | --- | --- |
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**Additional information such as any relevant current family circumstances:**

|  |
| --- |
|  |

**Professionals involved with the Pregnant Person:**

**General Practitioner:**

|  |  |  |  |
| --- | --- | --- | --- |
| GP Name: |  | Telephone: |  |
| Address: |  | Postcode: |  |
| Clinical Commissioning Group (CCG): |  | Email: |  |

**Medical Professionals:** please complete for obstetrician, neonatologist, midwife etc involved with pregnant person.

| Name | Hospital / Medical Community | Speciality | Telephone number | Email |
| --- | --- | --- | --- | --- |
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**Referrer:**

By completing this referral form you are confirming that the pregnant person has agreed to the referral and has been given the ‘Supporting Families, (An Introduction to EACH)’ leaflet. (available on EACH website)

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | Job title:(if relevant) |  |
| Role: |  | Organisation: |  |
| Telephone numbers: |  | Email: |  |
| Signature: |  | Date: |  |

**Please return this completed form to** each.referrals@nhs.net