ADHB Community Midwife Referral Form

TO BE COMPLETED BY CLIENT:

Full Name:	**Date of birth:**	**NHI:**
Home Address:	**Contact Details:** Mobile: Other:	
Auckland Residence: (if different to above)	**Next of Kin:** Name: Contact number:	
Family Doctor: Name: Address:		

Do you have a current Lead Maternity Carer (LMC)? (circle one)	YES / NO
Do you have a current LMC who is **unable** to continue your care in Auckland? (circle one)	YES / NO
If YES, LMC name and contact number:	

Signed……. Name……. Date……

PLEASE FILL IN THE QUESTIONNAIRE OVERLEAF:

IF YOU ARE CURRENTLY PREGNANT, COMPLETE SECTION A

IF YOU HAVE GIVEN BIRTH, COMPLETE SECTION B

SECTION A: Antenatal Information

Estimated Date of Delivery (EDD):	
Number of pregnancies, including current (Gravida):	**Number of babies born:** (Parity)

Do you know of any problems with your current pregnancy? (circle any that apply)

Twins or triplets, high blood pressure, diabetes, low lying placenta, small grown baby,

large grown baby, low iron levels, recurrent urinary tract infections

Other (please give details):

Did you have problems in previous pregnancies? (circle any that apply)

Caesarean birth, high blood pressure, diabetes, small grown baby, large grown baby,

large blood loss after birth, urinary tract infections,

Other (please give details):

Date and location of most recent antenatal check up:

SECTION B: Postnatal Information

Date and time of birth:

Number of weeks pregnant at time of birth?

Type of birth: (circle any that apply)
vaginal ventouse forceps
emergency caesarean planned caesarean

Were there any complications? (circle any that apply)
excessive bleeding infection poor wound healing
low iron levels difficulty going to the toilet
Other (please comment):

Do you have any stitches? (circle any that apply)
abdominal perineal
Other (please comment):

Current Method of feeding baby? (circle any that apply)
breast formula
Other (please comment):