Pregnancy Pre-Registration / Self-Referral Form

Please bring this form to your appointment, or to the Antenatal Booking Office (open Monday - Friday, 9am - 4pm) at 1st Floor Lanesborough Wing, St George's Hospital, Blackshaw Road, London SW17 0QT, or email: stgh-tr.stgpregnancyreferrals@nhs.uk Fax: 0208 725 3302 Tel: 0208 725 1914/1710

Please read through the form. Complete all sections. Shaded sections are essential.
If you attend or have an Early Pregnancy Scan please bring the scan report with this form.

ARE YOU REFERRING YOURSELF? ☐ YES ☐ NO			
HAS A GP ALREADY REFERRED YOU? ☐ YES ☐ NO			
PLEASE COMPLETE ALL SECTIONS OF THIS FORM			
Surname:		**Date of Birth: dd/mm/yy**	
First Name:		**Hospital No/MRN** (if known):	
Previous Surname:		**NHS No** (if known):	
Do you usually live in the UK?	☐ YES ☐ NO	**Country of Birth e.g. UK:**	
Address in the UK:			
Post code:		**Email:**	
Telephone number:		**Mobile number:**	
Can we contact you on this number by text messaging?			☐ YES ☐ NO
Address OUTSIDE the UK:			
Postcode:		**Country:**	
Contact telephone:		**Nationality:**	
GP details (if you are registered with a GP in the UK)			
GP Name:			
Practice Name:			
Address:			
Post Code:		**Gender**	**FEMALE**
Marital Status:		**Religion:**	
Do you require an Interpreter?	☐ YES ☐ NO	**Language spoken:**	
Past medical/pregnancy history			
First day of your last period Last Menstrual Period (LMP)?		**Please tell us when your baby is due (EDD) / /201**	
Have you had a scan? ☐ YES ☐ NO		**Date scan was done**	**/ / 201**
Height:		**Weight:**	
Do you have any communication needs e.g. hearing loss, visual impairment or learning disability? If yes, please complete and return the 'Accessible Information Needs' form on the website or available with this form			☐ YES ☐ NO
Have you had any previous pregnancies or related issues (such as a miscarriage after 13 weeks, neonatal death or pregnancy loss) that we should be aware of? **If yes, please provide details:**			☐ YES ☐ NO
Do you currently have, or have you had any other health problems: **If yes, please provide details:**			☐ YES ☐ NO

PLEASE TURN OVER THE PAGE AND COMPLETE ALL SECTIONS

Next of kin details

Surname:		**First Name:**	
Address:			
Post code:		**Mobile Tel:**	
Home Tel:		**Work Tel:**	

PLEASE COMPLETE THIS SECTION IN FULL

Passport number:	**Country of issue:**	**Passport expiry date:** D D M M Y Y
☐**Current United Kingdom passport**	☐**Current European Union**	
Dual Nationality:	**Date of entry into the UK:**	
Will you return to live in your home country? ☐**YES** ☐**NO**	**If yes, when?**	
☐**Current non-EU passport with valid entry visa**	**Visa No:**	
☐**Student visa** ☐**Visit visa**	**Visa expiry date:** D D M M Y Y	
☐**Asylum Registration Card (ARC)**	**ARC No.**	
☐**Other – please state:**		

ALL: YOUR STAY IN THE UK – You will be required to provide documentation at your appointment. Please read the patient information leaflet entitled Information for overseas visitors - hospital treatment and paying for care' for more information or contact the Overseas Patients team on 020 8725 4693 or 020 8725 3439

Please tell us about the purpose of your stay in the UK (check all that apply):

☐**Holiday/visit friends or family**	☐**On business**	☐**To live here permanently**	☐**To work**
☐**To study**	☐**To seek asylum**	☐**Other – please state:**	

How many months have you spent OUTSIDE the UK in the last 12 months?

☐ **None**	☐ **Up to 3 months**	☐ **3-6 months**	☐ **Over 6 months**

Please indicate the reason for any absence from the UK in the last 12 months (check all that apply)

☐ **I live in another country**	☐ **A holiday/to visit friends**	☐ **To work**	☐ **To study**
☐ **I frequently commute (business/second home overseas)**		☐ **Other – please state:**	

HEALTH OR TRAVEL INSURANCE DETAILS – If the UK is not your permanent place of residency

Do you have insurance?	☐ YES ☐ NO
Name and address of insurance provider:	
Membership number:	Insurance telephone:
Do you have a non-UK EHIC?	☐ YES ☐ NO

STUDENT DETAILS – If you have come to the UK to study

Name of college/university:		Telephone:	
Course dates	From D D M M Y Y	To D D M M Y Y	Number of hours/week:

How many weeks pregnant are you?		**Have you booked at another hospital?**	☐**YES** ☐**NO**
Name of hospital/birth centre you are currently booked at:			

PLEASE MOVE ON THE NEXT PAGE AND COMPLETE ALL SECTIONS

DECLARATION: TO BE COMPLETED BY ALL

This hospital may need to ask the Home Office to confirm your immigration status to help us decide if you are eligible for free NHS hospital treatment. In this case, your personal, non-clinical information will be sent to the Home Office. The information provided may be used and retained by the Home Office for its functions, which include enforcing immigration controls overseas, at the ports of entry and within the UK. The Home Office may also share this information with other law enforcement and authorised debt recovery agencies for purposes including national security, investigation and prosecution of crime, and collection of fines and civil penalties. If you are chargeable but fail to pay for NHS treatment for which you have been billed, it may result in a future immigration application to enter or remain in the UK being denied. Necessary (non-clinical) personal information may be passed via the Department of Health to the Home Office for this purpose.

Please read the leaflet entitled 'Information for overseas visitors - hospital treatment and paying for care' for more information or contact the Overseas Patients team on 020 8725 4693 or 020 8725 3439.

DECLARATION:

☐I have read and understood the reasons I have been asked to complete this form	
☐I agree to be contacted by the trust to confirm any details I have provided	
☐ I understand that the relevant official bodies may be contacted to verify any statement I have made.	
☐The information I have given on this form is correct to the best of my knowledge.	
☐ I understand that if I knowingly give false information then action may be taken against me. This may include referring the matter to the hospital's local counter fraud specialist and recovering any monies due.	
Signed:	**Date:**

If you are transferring your care, please bring your notes from your current hospital with you.