Royal Berkshire **NHS**

NHS Foundation Trust

Women's and Children's Division
Midwives Community Office
Maternity Block
Royal Berkshire Hospital
London Road
Reading
RG1 5AN

Community Midwives Booking Referral Form

Patient's Name	
Date of Birth	
Address (Incl Post Code)	
Contact Tel Number	
NHS Number	
Last menstruation period (1st day of last bleed)	
Interpreter required (Delete as appropriate) **[Please State Language]**	**YES / NO**
Please contact lady by: (Delete as appropriate)	**TEXT / PHONE / EMAIL / LETTER**
Patient's Email Address (If required)	

I would like to refer this lady to you for a midwifery booking appointment.

Please attach a brief health summary detailing any significant past medical or social history.

NAME OF GP	SURGERY NAME	DATE
	Chapel Row Surgery	

Please email referral to: rbft.maternityreferrals@nhs.net

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Midwives use only:

Appointment date………………………Contacted via…… **TEXT/PHONE/EMAIL/LETTER**

Details sent to midwife…………………Lady given midwife's details…………………..

Details emailed to maternity booking by………………………………. Date………………