**Are you pregnant and wish to attend Belfast HSC Trust for your maternity care?**

**As soon as you have a positive pregnancy test, you can refer yourself directly for maternity care within the Belfast HSC Trust using the online registration form at the bottom of the page.**

**Please use a tablet, laptop or computer to do so but NOT a mobile phone. Save the completed registration form to your device (not your mobile phone) and send the referral as an attachment using the email address below.**

Following receipt of this referral, we will allocate you an appointment around 12th week of your pregnancy. This appointment will be posted to you approximately 2 weeks prior to your appointment date.

You will also need to inform your GP of your pregnancy.

We recommend that you commence taking the following:

* **Folic acid =** 400 micrograms per day. **(NB. If there is a family history of Spina bifida or you have a BMI greater than 30, you will need to see your GP as the dose will be higher).**
* **Vitamin D =**10 micrograms per day.
* Alternatively, you can buy a suitable **multivitamin for pregnancy** that contains both of these. It is important you start this medication as soon as possible and continue until at least 12 weeks of pregnancy.

**It is important to ensure ALL details are correct to allow a smooth and timely referral to maternity services.**

Please ensure your GP has your correct name, address and telephone number.

Please return completed forms as below:

By Email: [MaternityReferral@belfasttrust.hscni.net](mailto:MaternityReferral@belfasttrust.hscni.net)

By Post: Maternity Appointments

C/O Medical Records

1st Floor, Royal Jubilee Maternity

BHSCT

Grosvenor Road

Belfast BT12 2BA

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Title: | Forenames: | | | | | Surname: | | |
| Age: | Date of birth: | | | | | Previous surname: | | |
| Address including postcode: | | | | Mobile number: | | | | |
| Landline number: | | | | |
| Email address: | | | | |
|  | | | |  | | | | |
| GP name and address: | | | | | Weight\_\_\_\_\_\_\_\_\_\_\_\_\_  Height \_\_\_\_\_\_\_\_\_\_\_\_\_  BMI (if known) \_\_\_\_\_\_\_\_\_\_\_\_\_\_  Do you smoke: If yes, how many \_\_\_\_\_ | | | |
| Nationality: | | | | | Language spoken:  Interpreter needed: YES / NO | | | |
| First day of last menstrual period or best guess: | | | | | Number of previous pregnancies: | | | |
| Type of birth and numbers: | | Vaginal | Caesarean Section | | | | Stillbirth/Neonatal Death | Miscarriage |
| Year/s of birth: | |  |  | | | |  |  |
| Please give details of any problems in previous pregnancies: | | | | | | | | |
| Details of any medical conditions, operations or allergies. Please include details of any current medications  **If you are taking prescribed medication, please contact your GP as soon as possible.** | | | | | | | | |
| **I would like to consider giving birth in the Midwife-Led Unit in the Mater: Y/N** | | | | | | | | |
| Please add any other information you feel is relevant to your ongoing care: | | | | | | | | |

**If you have any queries about this form or if you have not received an appointment by the 12th week of your pregnancy, please phone:**

**Maternity appointments clerk: (028) 96151075.**