

Your Details

Single Married / CP Partner Separated Divorced Widowed

Family name at birth

Country of birth If not UK, year of entry

Faith / Religion Citizenship status

Disability No Yes Details

Partner's Details

Name

Address if different

Postcode:

Occupation Date of birth / /

UK citizenship status If not born in UK, year of entry

Social Assessment - Booking

	No		Yes		2nd Assessment		3rd Assessment		Referred (Details: page 11)
	No	Yes	No	Yes	No	Yes	No	Yes	
Has difficulty understanding English	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any difficulties reading / writing English	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Needs help understanding pregnancy notes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Needs help completing forms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Highest educational qualification <input type="text"/>									
Employment status Occupation <input type="text"/>									
Employed <input type="checkbox"/> F/T <input type="checkbox"/> P/T <input type="checkbox"/> Home <input type="checkbox"/> Student <input type="checkbox"/> Sick <input type="checkbox"/> U/E <input type="checkbox"/> Retired <input type="checkbox"/>									
Housing: Owns <input type="checkbox"/> Rents <input type="checkbox"/> With family/ friends <input type="checkbox"/> UKBA <input type="checkbox"/> NFA <input type="checkbox"/>									
Care services <input type="checkbox"/> Temporary accomodation <input type="checkbox"/> Other <input type="text"/>									<input type="checkbox"/>
Entitled to claim benefits (income support, child tax credits, job seeker etc.) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has support from partner / family / friend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any household member had/has social services support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Name of social worker(s)/ <input type="text"/>									
Other Professionals (CAF) <input type="text"/>									

Smoking -Booking	No		Yes		Second		Third		Drug use -Booking		2nd		3rd	
	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes
Record plan on Page 11	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Record plan on Page 11	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you smoke, or use tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you use street drugs, gas or glue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
No. per day <input type="text"/>									Details <input type="text"/>					
Have you smoked in the last 12 months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you receiving treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
When did you give up <input type="text"/>									Referred to substance misuse advisor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Referred to smoking cessation advisor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anyone else in home use street drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anyone else in home smoke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol Record plan on Page 11	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Referred to smoking cessation services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you drink alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
									Pre-pregnancy	Currently	Currently	Currently	Currently	Currently
									Units per week <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
									Referred to substance misuse advisor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Ethnic Origin (If mixed, tick more than one box)

The term Ethnic Origin is to describe where your family originates from, as distinct from where you were born. This information will help us to support which blood screening tests you should be offered (see p. 6) and to produce a customised growth chart for your baby (see p 12).

	You	Baby's father		You	Baby's father
Africa			Europe		
North Africa (eg Morocco, Algeria)	<input type="checkbox"/>	<input type="checkbox"/>	Britain (England, Scotland & Wales)	<input type="checkbox"/>	<input type="checkbox"/>
Sub-Sahara (eg Somalia, Kenya, Nigeria)	<input type="checkbox"/>	<input type="checkbox"/>	Ireland (incl Northern Ireland, Eire)	<input type="checkbox"/>	<input type="checkbox"/>
Other: <input type="text"/>			Northern Europe (eg Denmark, Norway, Sweden)	<input type="checkbox"/>	<input type="checkbox"/>
Asia			Western Europe (eg France, Germany, Netherlands)	<input type="checkbox"/>	<input type="checkbox"/>
India	<input type="checkbox"/>	<input type="checkbox"/>	Eastern Europe (eg Balkans, Poland, Russia)	<input type="checkbox"/>	<input type="checkbox"/>
Pakistan	<input type="checkbox"/>	<input type="checkbox"/>	Southern Europe (eg Cyprus, Greece, Italy, Spain, Turkey)	<input type="checkbox"/>	<input type="checkbox"/>
Bangladesh	<input type="checkbox"/>	<input type="checkbox"/>	Other: <input type="text"/>		
China	<input type="checkbox"/>	<input type="checkbox"/>	Middle East (eg Egypt, Israel, Syria, Yemen)	<input type="checkbox"/>	<input type="checkbox"/>
Far East Asia - Other (eg Japan, Korea)	<input type="checkbox"/>	<input type="checkbox"/>	Other: <input type="text"/>		
South East Asia (eg Malaysia, Thailand, Philippines)	<input type="checkbox"/>	<input type="checkbox"/>	Other:		
Other: <input type="text"/>			Declined to give information	<input type="checkbox"/>	<input type="checkbox"/>
Caribbean					
(eg Barbados, Jamaica, Trinidad & Tobago)	<input type="checkbox"/>	<input type="checkbox"/>			

