Midwife referral form for jaundiced infants in the community
H@H: 07557202900

Baby's Name		**Mother's Name**	
		Mother's GP name **Islington CCG**	**Yes/ No**
Time and DOB		**DOB**	
Hospital Number		**Hospital Number**	
Hospital where Delivered		**Home Address**	
Gestation		**Telephone Number**	
Type of Delivery		**Blood Group**	
Ethnic Origin		**Rhesus Factor and any known atypical antibodies.**	

Birth weight		**Age in days**	
Current Weight		**TcB level**	
Feeding Method		**Date of test**	
Percentage weight loss		**Time of test**	
Meets criteria for Hospital at Home referral? **Yes / No**		**Accepted by Hospital at Home?** **Yes / No**	

Date and time of referral:	
Name and designation of professional receiving referral:	
Name of midwife making referral:	