TELEPHONE TRIAGE ASSESSMENT

Patient Name:	**Date:**		**Time:**
Address:	**Telephone Number:**		
	Gravida:	**Parity:**	**Gestation:**
Pregnancy: **Singleton** ☐ **Multiple** ☐	**EDD:**	**MLC** ☐ **CLC** ☐ **Consultants Name:**	

Primary reason for calling Triage	**Abdominal pain**		**PV Bleed**		**Hypertension**	
	DFM		**Ruptured membranes**		**Suspected labour**	
	Other					
Details:						
Relevant current obstetric history & details of prev. deliveries						
Additional information Inc. any relevant medical history:						
Advice given:						

Plan (please circle)	**Stay at Home**	**Attend triage**	**Referred to other dept: A&E / DAU/ MLU / CDS**	**Referred to GP**	**Advise to contact 999**
CDS Co-ordinator / Manager informed: **Yes** ☐ **No** ☐					

Telephone call taken by	**Print Name**	**PIN**
	Signature	

SBAR Completed: ☐

PLEASE ATTACH TO HOSPITAL NOTES AND FILE ON ADMISSION