

GCRM PREGNANCY OUTCOME FORM

ADDRESS (Current)

Please affix GCRM patient label

PREGNANCY SCAN DATE ____ / ____ / ____ GESTATION ____ Wks ____ days

NUMBER OF SACS _____ NUMBER OF FHs _____

DELIVERY HOSPITAL _____

	Baby 1	Baby 2
DELIVERY DATE		
GESTATION (Weeks)		
TYPE OF DELIVERY		
SEX(s)		
BIRTH WEIGHT (s)		
BABY FULL NAME (s)		
BABY NHS Number (s)		

ANY RELEVANT INFORMATION

If your pregnancy had any complications please provide the date and circle the closest description.

OUTCOME DATE ____ / ____ / ____

OUTCOME:

Miscarriage / Termination / Still birth / Neonatal Death / Other _____

If you need any assistance with the completion of this form please call
GCRM on 0141 891 8749.
When complete please return the form to;
GCRM Ltd, 21 Fifty Pitches Way, Cardonald Business Park, Glasgow, G51 4FD.