**Maternity Care Referral Form**

Provided this form is complete, it constitutes a valid referral to Djerriwarrh Health Service (Bacchus Marsh & Melton Regional Hospital), Werribee Mercy Hospital and Western Health (Sunshine Hospital).

**Fax referral to:**

Djerriwarrh Health Service (Dr Nisha Khot – Head of Unit) Fax: 9746 0668

Werribee Mercy Hospital (Dr Jacqueline Van Dam – Head of Unit) Fax: 8754 6710

Western Health (Dr Elske Posma – Head of Unit) Fax: 9055 2125

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| **Patient Details** | | | | | | | | **Referring Doctor Details** | |
| First Name: | | | | | | Last Name: | | Name: | |
| Previous last name: | | | |  | | | | Practice Name: | |
| Date of birth: | | |  | | | | | Practice address: | |
| Address: |  | | | | | | | Suburb: Postcode: | |
|  | | | | | | | | Ph: | |
| Suburb: | | | | | | Postcode: | | Fax: | |
| Home phone: | |  | | | | Mobile: |  | Provider number: | |
| Medicare no.: | |  | | | | | | Date: | |
|  | |  | | | | | |  | |
| Interpreter required: | | | | | Yes – specify language: | | | | Disabilities or special needs  Yes – please detail: |

**Shared Care**

I/My practice is able to provide shared care to the patient: Yes No

Please nominate suggested shared care practitioner:………………………………… Comment:

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| **Current Obstetric History** | | | | | | | | | |
| LNMP: |  | | |  | | Estimated delivery date: | |  | |
| Gravida: | |  | Parity: | |  | Known multiple pregnancy: | | | Yes  No  |
| Height: | cm | | Weight: | | kg | BMI\*: |  | \*must be included to enable triage and booking | |

**Tests/investigations (please attach results to referral if available or fax when complete to DjHS 9746 0668, Werribee Mercy Hospital 8754 6710, Western Health 9055 2125):**

**Required tests:**

FBE, ferritin, Thalassemia testing/Hb electrophoresis, Blood group and antibodies, Rubella, Hepatitis B/C, HIV, Syphilis, MSU

**Tests to consider:**

Dating ultrasound, vitamin D, chlamydia, morphology scan.

Early GTT if previous GDM, PCOS, BMI >35, family history of diabetes, previous large baby >4500g

Please provide results and/or provider\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Aneuploidy Screening (*should be discussed and offered to all women irrespective of age)***

Patient has decided to have aneuploidy screening  Yes  No

If yes: please provide results and/or provider\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Obstetric History:**  Not applicable - primigravida  Not applicable - no relevant past obstetric

|  |  |  |  |
| --- | --- | --- | --- |
| Previous stillbirth | Yes | Gestational Diabetes | Yes |
| Previous fetal abnormality (specify) | Yes | Previous HDIP/HELLP syndrome or severe pre-eclampsia | Yes |
| Mid trimester loss OR miscarriage x3 or more | Yes | Obstetric Cholestasis | Yes |
| Preterm birth <37/40 (gestation) \_\_\_\_\_\_\_ | Yes | Maternal red cell antibodies | Yes |
| IUGR or <2800g at term | Yes | PPH >1000mls | Yes |
| Cervical cerclage | Yes | Previous Neonatal Alloimmune Thrombocytopenia | Yes |
| Placenta l abnormalities/abruption | Yes | Perinatal psychosis | Yes |
| Previous caesarean Number (if yes): \_\_\_\_\_\_\_ | Yes |  |  |

**Risk factors relevant to pregnancy:**  Not applicable - no relevant risk factors

|  |  |  |  |
| --- | --- | --- | --- |
| Smoking in the last 12 months | Yes |  |  |
| Alcohol and other drugs (specify) | Yes | Diabetes pre-pregnancy | Yes |
| Psychiatric disorders | Yes | Other endocrine disorder (specify) | Yes |
| Family history of genetic disease/anomalies (specify) | Yes | Thalassaemia | Yes |
| Heart Disease | Yes | Haematological/Coagulation disorder e.g. sickle cell | Yes |
| Hypertension/or on medication | Yes | Hep B carrier or Hep C | Yes |
| Respiratory Disorder including severe asthma | Yes | Infectious disease e.g. HIV | Yes |
| Gastrointestinal/liver disorder | Yes | Current malignancy | Yes |
| Renal Disorder | Yes | Previous chemotherapy | Yes |
| Neurological Disorder e.g. epilepsy | Yes | Uterine anomalies/fibroids | Yes |
| Rheumatologic Disorder e.g. SLE | Yes | Uterine/cervical surgery e.g. cone biopsy/LLETZ procedure | Yes |

**Medications (including vitamins and supplements):**

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**Allergies:**

**Other relevant information:**

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Doctor’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Appointment details will be sent to referring GP and patient.**

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