djerriwarrh health services | Mercy Health Care first | Western Health

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

Patient Details

First Name: Last Name:
Previous last name:
Date of birth:
Address:

Suburb: Postcode:
Home phone: Mobile:
Medicare no.:

Interpreter required: ❑Yes – specify language:

Referring Doctor Details

Name:
Practice Name:
Practice address:
Suburb: Postcode:
Ph:
Fax:
Provider number:
Date:

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:

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____

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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
Placental 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):

________________________________ ________________________________
________________________________ ________________________________
________________________________ ________________________________
________________________________ ________________________________

Allergies:

Other relevant information:

____
____
____
____
____

Doctors signature: ____ Date:__________________________

Appointment details will be sent to referring GP and patient.

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