

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 _____

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

Previous stillbirth	<input type="checkbox"/> Yes	Gestational Diabetes	<input type="checkbox"/> Yes
Previous fetal abnormality (specify)	<input type="checkbox"/> Yes	Previous HDIP/HELLP syndrome or severe pre-eclampsia	<input type="checkbox"/> Yes
Mid trimester loss OR miscarriage x3 or more	<input type="checkbox"/> Yes	Obstetric Cholestasis	<input type="checkbox"/> Yes
Preterm birth <37/40 (gestation) _____	<input type="checkbox"/> Yes	Maternal red cell antibodies	<input type="checkbox"/> Yes
IUGR or <2800g at term	<input type="checkbox"/> Yes	PPH >100mls	<input type="checkbox"/> Yes
Cervical cerclage	<input type="checkbox"/> Yes	Previous Neonatal Alloimmune Thrombocytopenia	<input type="checkbox"/> Yes
Placental abnormalities/abruption	<input type="checkbox"/> Yes	Perinatal psychosis	<input type="checkbox"/> Yes
Previous caesarean Number (if yes): _____	<input type="checkbox"/> Yes		

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

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

Medications (including vitamins and supplements):

_____	_____
_____	_____
_____	_____
_____	_____

Allergies:

Other relevant information:

Doctor's signature: _____ Date: _____

Appointment details will be sent to referring GP and patient.

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