Maternity Care Referral Form

Provided this form is complete, it constitutes a valid referral to Werribee Mercy Hospital and Western Health (Joan Kirner Women's & Children's and Bacchus Marsh Campuses).

Fax referral to:

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

Western Health (**Joan Kirner and Bacchus Marsh hospital**) (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:

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:

Does the patient identify as Aboriginal or Torres Strait Islander? ☐ Yes ☐ No

WH only: Has the patient requested a homebirth? ☐ Yes ☐ No

Shared Care

Patient would like shared care? ☐ Yes ☐ No

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

Please nominate suggested shared care practitioner: .....

Comment: .....

Current Obstetric History- Mandatory Section

LNMP: _____ Estimated Delivery date: _____

Gravida: _____ Parity: _____ Known multiple pregnancy: _____

Height: _____ cm Weight: _____ kg BMI*:

Tests/investigations

Please attach results to referral if available or fax when complete to: **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 or gestation)***

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 ☐ **If previous birth summary, please forward with referral**	
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):			

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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