|  |  |  |
| --- | --- | --- |
| https://intranet.mercyhealth.com.au/about-us/PublishingImages/HighRes_Mercy%20Health_Full%20Colour%20Logo.jpg | **Maternity Care Referral Form** | |
| Mercy Public Hospital Inc- Mercy Hospital for Women (MHW) | |
| 163 Studley Road, Heidelberg Vic 3084 | **Phone:** 03 8458 4111 **Fax:** 038458 4205 |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Patient Details** | | | | | | | | **Previous MHW patient?** | | | | | | | | | | | | |  | | **Yes** | | | |  | **No** |
| **Full Name:** | | Click here to enter text. | | | | | | | **ATSI - Self:** | | | Choose an item. | | | | | | | | | | | | | | | | | |
| **Date of Birth:** | | Click here to enter text. | | | | | | | **ATSI - Spouse:** | | | Choose an item. | | | | | | | | | | | | | | | | | |
| **Address:** | | Click here to enter text. | | | | | | | **Eligible for Medicare?** | | | |  | | **Yes** | | |  | | | **No** | | | | | | | | |
| **Suburb:** | | Click here to enter text. | | | **Post Code:** | | | Click here to enter text.  **4**  **4** | **Medicare No:** | | Click here to enter text. | | | | | **IRN** | | | Ch | | | | **Exp. Date:** | | | | Mm/yyyy | | |
| **Phone (H):** | | Click here to enter text. | | | | | | | **Health Insurance Fund:** | | | | | Click here to enter text. | | | | | | | | | | | | | | | |
| **Mobile:** | | Click here to enter text. | | | | | | | **Health Insurance No.:** | | | | | Click here to enter text. | | | | | | | | | | | | | | | |
| **Interpreter Required?** | | |  | **Yes** | |  | **No** | | **Disability or special needs:** | | | | | | | |  | | | **Yes** | | | | |  | **No** | | | |
| **Language:** | | Click here to enter text. | | | | | | | **Specify**: | Click here to enter text. | | | | | | | | | | | | | | | | | | | |

**Referring Doctor**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Print name:** | | Click here to enter text. | | | | **Provider no.:** | | | Click here to enter text. |
| **Practice Name & Address:** | | | Click here to enter text. | | | | | | |
| **Postcode:** | Click here to enter text. | | | **Phone:** | Click here to enter text. | | **Fax :** | Click here to enter text. | |

**Current Obstetric History**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **LNMP:** | Click here to enter text. | | | | **Estimated delivery date:** | | | Click here to enter text. | | | | | | | |
| **Gravida:** | Click here to enter text. | **Parity:** | Click here to enter text. | | **Known multiple pregnancy** | | | | |  | **Yes** | |  | | **No** |
| **Height (cm):** | Click here to enter text. | **Weight (kg):** | | Click here to enter text. | **BMI\*:** | *\*must be included to enable triage and booking* | | | | | | | | | |
| **Last PAP test ( *date & result*):** | | Click here to enter text. | | | **Female circumcision:** | |  | | **Yes** | | |  | | **No** | |

**Past Obstetric History X if applicable**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Previous severe pre-eclampsia |  | Gestational diabetes |  | Rhesus isoimmunisation |
|  | Previous small baby <2800g (5lb 8oz) |  | Previous caesarean |  | Previous preterm birth <35 weeks |
|  | Miscarriage x 3 or more |  | Mid trimester loss |  |  |

**Medical History**  **X** *if applicable*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Diabetes |  | Previous cone biopsy |  | Heart disease |
|  | Anaemia |  | High blood pressure requiring medications |  | Epilepsy (on treatment) |
|  | Asthma (currently on medication) |  | Psychiatric disorders |  | Illicit drug use |
|  | Thyroid disease |  | Current smoker |  | Allergies |
|  | DVT or pulmonary |  | Thalassemia/haemoglobinopathy |  | Alcohol or other drugs |

**Other Relevant Information** *(including current medications)* **CareType**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Click here to enter text. |  |  | Shared Care |  | Team Maternity Care |
| Click here to enter text. |  |  | Routine |  | Case Load Midwifery |
| Click here to enter text. |  |  | Transitions |  | Urgent (*Why?)* |

**Investigations Ordered: Pathology provider is:** *Give copy of results to your patient to bring to her first**appt***.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | FBE |  | HIV serology |  | Morphology 20 week U/S |
|  | Blood group and antibodies |  | Syphilis |  | Vitamin D |
|  | Rubella |  | MSU / urinalysis |  | Ferritin |
|  | Hepatitis B |  | Dating U/S (if required) |  | Thalassemia testing |
|  | Hepatitis C |  | Varicella |  | Screen for Down Syndrome |

**Doctor’s signature: Date:**

**You should receive written notification from us within 8 working days confirming receipt of your referral. Failure to supply all the required information may lead to a delay in your referral being processed as we may need to seek the additional information.**

**Pages to follow (including cover sheet):**

**IMPORTANT NOTICE – PRIVILEGED AND CONFIDENTIAL MESSAGE**

This facsimile transmission is intended for the exclusive use of the person or hospital to which it is addressed and may contain information that by law is privileged or confidential. If the reader of the facsimile transmission is not the intended recipient, you are hereby notified that any disclosure, distribution of copying of this transmission is prohibited by law, and the contents must be kept strictly confidential. If you have received this transmission in error, kindly notify us immediately and return the original to us at the above address.