|  |  |
| --- | --- |
| https://intranet.mercyhealth.com.au/about-us/PublishingImages/HighRes_Mercy%20Health_Full%20Colour%20Logo.jpg | **Perinatal Medicine Clinic Referral Form** |
| Mercy Public Hospital Inc- Mercy Hospital for Women |
| 163 Studley Road, Heidelberg Vic 3084 | **Phone:** 03 8458 4248 **Fax:** 038458 4504 |

|  |  |  |  |
| --- | --- | --- | --- |
| **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:** |   |
| **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** |
| **BMI\*:** | Click here to enter text. *\*must be included to enable triage and booking* |

**Reason for Referral / Diagnosis:**

|  |
| --- |
| Click here to enter text. |

**Relevant co-morbidities: obstetric, medical, surgical, mental health, genetic, family:**

|  |
| --- |
| Click here to enter text. |

**Medicines & Allergies:**

|  |
| --- |
| Click here to enter text. |

**Investigations Ordered: (Please attach all relevant results to assist us to triage correctly)**

|  |
| --- |
| Click here to enter text. |

**Referral Notes**

|  |
| --- |
| Click here to enter text. |

**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.