**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

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| --- | --- |
| **Patient Details** | **Referring Doctor Details** |
| First Name:  | Last Name: | Name: |
| Previous last name: |  | Practice Name: |
| Date of birth: |  | Practice address: |
| Address: |  | Suburb: | Postcode: |
|  | Ph: |
| Suburb: | Postcode: | Fax: |
| Home phone: |  | Mobile: |  | Provider number: |
| Medicare no.: |  | Date: |
|  |  |  |
| Interpreter required: | [ ] Yes – specify language: | 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:

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| **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 history

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| --- | --- | --- | --- |
| 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  |
| Placenta l abnormalities/abruption | [ ]  Yes  | Perinatal psychosis | [ ]  Yes  |
| Previous caesarean Number (if yes): \_\_\_\_\_\_\_ | [ ]  Yes  |  |  |

**Risk factors relevant to pregnancy:** [ ]  Not applicable - no relevant risk factors

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| --- | --- | --- | --- |
| 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):**

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|  |

**Allergies:**

**Other relevant information:**

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|  |

Doctor’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Appointment details will be sent to referring GP and patient.**

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