djerriwarrh health services
bacchus marsh • melton • caroline springs

Mercy Health
Care first

Western Health

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_____

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

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): _____	☐ 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:

Doctor's signature: _____Date:_____

Appointment details will be sent to referring GP and patient.