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| Mercy Hospital for WomenMaternity Referral |  | **Referral Date:** 28/11/2019 Head of Unit - Dr Gillian Paulsen |

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| **Fax number for all referrals: 8458 4205 Outpatient enquiries: ph 8458 4111**Provided this form is complete, it constitutes a valid referral to Mercy Hospital for Women |

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| Patient Details |
| Last/Family name: | First name: |
| Previous last name: | Sex: Choose an item. |
| Date of birth: | ATSI status: Choose an item. |
| Address: | Home telephone No.: |
| Suburb: | Mobile number: |
| Postcode: | Email: |
| NOK/Carer: | Preferred contact method: |
| NOK relationship: | Medicare no.: |
| NOK contact no.: | Pensioner/Concession/Health/DVA No.: |
| Interpreter required: [ ]  Yes [ ]  No Specify language: |
| Previous patient at Mercy Health: [ ]  Yes [ ]  No  | Mercy Health UR Number (if known):  |
| The patient has agreed to the referral and the sharing of their personal and health information with the health service [ ]  Yes [ ]  No  |

Referring Doctor Details

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| Referring Doctor: |  |  Provider number: |  |
| Practice Name: |  |
| Practice Address: |  |
| Suburb: |  |
| Postcode: |  | Phone No: |  |
| Email: |  | Fax: |  |
| Preferred method of communication: |  |

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| **Patient’s usual GP** (if not the same as referring doctor) |
| Name: |  | Clinic: |  |

Shared Care

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| I/My practice is able to provide shared care to the patient: [ ] Yes [ ] No Please nominate suggested shared care practitioner:………………………………… Comment: |
| Medications: (including vitamins and supplements) | Allergies:  |
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Tests/investigations (please attach results to referral if available or fax when complete to relevant hospital)

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| **Required tests:**FBE, Hb electrophoresis, Blood group and antibodies, Rubella, Hepatitis B/C, HIV, Syphilis, MSU**Tests to consider:**Dating ultrasound, chlamydia, morphology scan, ferritin, Thalassemia testingEarly GTT (to be completed after 12 weeks) if previous GDM, PCOS, BMI >35, family history of diabetes, previous large baby >4500gPlease 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 [ ]  NoIf yes: please provide results and/or provider\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**If the required investigation/test results are not attached the referral will not be accepted by Mercy Health** |

Current Obstetric History

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| LNMP: |  |  | Estimated delivery date:  |  |
| Gravida: |  | Parity: |  | Known multiple pregnancy: | [ ]  Yes [ ]  No  |
| Height: | cm | Weight: |  kg | BMI\*: |  | \*must be included to enable triage and booking |

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  | Diabetes pre-pregnancy  | [ ]  Yes  |
| Alcohol and other drugs (specify) | [ ]  Yes  | Thalassaemia  | [ ]  Yes  |
| Psychiatric disorders  | [ ]  Yes  | Haematological/Coagulation disorder e.g. sickle cell | [ ]  Yes  |
| Family history of genetic disease/anomalies(specify): | [ ]  Yes  | Other endocrine disorder(specify): | [ ]  Yes  |
| Heart Disease  | [ ]  Yes  | Hep B carrier or Hep C | [ ]  Yes |
| Hypertension/or on medication | [ ]  Yes  | Infectious disease e.g. HIV | [ ]  Yes  |
| Respiratory Disorder including severe asthma | [ ]  Yes  | Current malignancy | [ ]  Yes  |
| Gastrointestinal/liver disorder | [ ]  Yes  | Previous chemotherapy | [ ]  Yes  |
| Renal Disorder  | [ ]  Yes  | Uterine anomalies/fibroids | [ ]  Yes  |
| Neurological Disorder e.g. epilepsy  | [ ]  Yes  | Uterine/cervical surgery e.g. cone biopsy/LLETZ procedure | [ ]  Yes  |
| Rheumatologic Disorder e.g. SLE | [ ]  Yes  |

Other relevant information*(eg management to date, current services, impact of the problem on the patient)***:**

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

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