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| Mercy Hospital for Women  Maternity Referral | A logo with a cross and a circle  Description automatically generated | **Referral Date:** 10/07/2024 |

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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: | Aboriginal & Torres Strait Islander status: Choose an item. |
| Address: | Home telephone No.: |
| Suburb: | Mobile number: |
| Postcode: | Email: |
| Preferred contact method: | Medicare no.: Reference: Non eligible |
| NOK/Carer: | Private Health Fund: |
| NOK relationship: | Private Health 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 testing  Early GTT (to be completed after 12 weeks) 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **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.**