Surname, First name, DOB

Mercy Hospital for Women Maternity Referral	Mercy Health Care first	**Referral Date:**

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

Patient Details

Last/Family name:	First name:
Previous last name:	Sex: Select
Date of birth:	Aboriginal & Torres Strait Islander status: Select
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

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

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

Shared Care

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:

Tests/investigations (please attach results to referral if available or fax when complete to relevant hospital)

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

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

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	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)*:

Doctor's signature: _____Date:_____

Appointment details will be sent to referring GP and patient.