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| **Maternity Care Referral Form** Provided this form is complete, it constitutes a valid referral to Werribee Mercy Hospital and Western Health (Joan Kirner Women’s & Children’s hospital and Bacchus Marsh hospital). |
| **Fax referral to:**Werribee Mercy Hospital (Dr Jacqueline Van Dam – Head of Unit) Western Health (Joan Kirner and Bacchus Marsh hospital) (Dr Elske Posma Head of Unit) | **Fax: 8754 6710****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: |
| Suburb: |  | Postcode: |  | Ph.: |  |
| Home phone: |  | Fax: |  |
| Medicare no.: |  | Provider number: |  |
|  |  |  | Date: |  |
| Interpreter required: | [ ]  Yes – specify language: |  | Disabilities or special needs |
|  |  |  |  | [ ]  Yes – please detail: |  |
| Does the patient identify as Aboriginal or Torres Strait Islander? | [ ]  Yes[ ]  No |  |
| **WH only:** Has the patient requested a homebirth? | [ ]  Yes[ ]  No |  |
| **WH only - Shared Care:**[ ]  **Patient would like shared care?** [ ]  Yes [ ]  NoI/My practice is able to provide shared care to the patient: [ ]  Yes [ ]  NoPlease nominate suggested shared care practitioner: Comment:  |

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| **Current Obstetric History** |  |
| LNMP: |  | Estimated Delivery date: |  |  |
| Gravida: |  | Parity: |  | Known multiple pregnancy: |  |  |
| Height: | cm | Weight: | kg | BMI\*: |  |  |
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| **Tests/investigations** **Please attach results to referral if available or fax when complete to: 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 >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:  |

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| **Past Obstetric History:** [ ]  Not applicable - primigravida | [ ]  Not applicable - no relevant past obstetric[ ]  **If previous birth summary, please forward with referral** |
| 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):  |

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| **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 |

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| **Medications (including vitamins and supplements):** |
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| **Allergies:****Other relevant information:** |
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| **Doctors signature:** |  | **Date:** |  |

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

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