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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  No  I/My practice is able to provide shared care to the patient:  Yes  No  Please 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 >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  **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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