

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)

Fax: 8754 6710

Western Health (Joan Kirner and Bacchus Marsh hospital) (Dr Elske Posma Head of Unit)

Fax: 9055 2125

<p><u>Patient Details</u></p> <p>First Name: _____ Last Name: _____</p> <p>Previous last name: _____</p> <p>Date of birth: _____</p> <p>Address: _____</p> <p>Suburb: _____ Postcode: _____</p> <p>Home phone: _____</p> <p>Medicare no.: _____</p> <p>Interpreter required: <input type="checkbox"/> Yes – specify language: _____</p>	<p><u>Referring Doctor Details</u></p> <p>Name: _____</p> <p>Practice Name: _____</p> <p>Practice address: _____</p> <p>Suburb: _____ Postcode: _____</p> <p>Ph.: _____</p> <p>Fax: _____</p> <p>Provider number: _____</p> <p>Date: _____</p> <p>Disabilities or special needs <input type="checkbox"/> Yes – please detail: _____</p>
<p>Does the patient identify as Aboriginal or Torres Strait Islander? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p><u>WH only:</u> Has the patient requested a homebirth? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p><u>WH only - Shared Care</u></p> <p><input type="checkbox"/> Patient would like shared care? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>I/My practice is able to provide shared care to the patient: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Please nominate suggested shared care practitioner:</p> <p>Comment:</p>	

<u>Current Obstetric History</u>	
LNMP: _____	Estimated Delivery date: _____
Gravida: _____ Parity: _____	Known multiple pregnancy: _____
Height: _____ cm Weight: _____ kg	BMI*: _____

<u>Tests/investigations</u>	
Please attach results to referral if available or fax when complete to: Werribee Mercy Hospital: 8754 6710 Western Health: 9055 2125	
<u>Required tests:</u> FBE, ferritin, Thalassemia testing / Hb electrophoresis, Blood group and antibodies, Rubella, Hepatitis B/C, HIV, Syphilis, MSU	
<u>Tests to consider:</u> 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:	
<u>Aneuploidy Screening (should be discussed and offered to all women irrespective of age)</u>	
Patient has decided to have aneuploidy screening <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes: please provide results and/or provider:	

Past Obstetric History: <input type="checkbox"/> Not applicable - primigravida <input type="checkbox"/> Not applicable - no relevant past obstetric			
<input type="checkbox"/> If previous birth summary, please forward with referral			
Previous stillbirth	<input type="checkbox"/> Yes	Gestational Diabetes	<input type="checkbox"/> Yes
Previous fetal abnormality (specify)	<input type="checkbox"/> Yes	Previous HDIP/HELLP syndrome or severe pre-eclampsia	<input type="checkbox"/> Yes
Mid trimester loss OR miscarriage x3 or more	<input type="checkbox"/> Yes	Obstetric Cholestasis	<input type="checkbox"/> Yes
Preterm birth <37/40 (gestation) _____	<input type="checkbox"/> Yes	Maternal red cell antibodies	<input type="checkbox"/> Yes
IUGR or <2800g at term	<input type="checkbox"/> Yes	PPH >1000mls	<input type="checkbox"/> Yes
Cervical cerclage	<input type="checkbox"/> Yes	Previous Neonatal Alloimmune Thrombocytopenia	<input type="checkbox"/> Yes
Placental abnormalities/abruption	<input type="checkbox"/> Yes	Perinatal psychosis	<input type="checkbox"/> Yes
Previous caesarean Number(if yes):			

Risk factors relevant to pregnancy: <input type="checkbox"/> Not applicable - no relevant risk factors			
Smoking in the last 12 months	<input type="checkbox"/> Yes		
Alcohol and other drugs (specify)	<input type="checkbox"/> Yes	Diabetes pre-pregnancy	<input type="checkbox"/> Yes
Psychiatric disorders	<input type="checkbox"/> Yes	Other endocrine disorder (specify)	<input type="checkbox"/> Yes
Family history of genetic disease / anomalies (specify)	<input type="checkbox"/> Yes	Thalassaemia	<input type="checkbox"/> Yes
Heart Disease	<input type="checkbox"/> Yes	Haematological / Coagulation disorder e.g. sickle cell	<input type="checkbox"/> Yes
Hypertension / or on medication	<input type="checkbox"/> Yes	Hep B carrier or Hep C	<input type="checkbox"/> Yes
Respiratory Disorder including severe asthma	<input type="checkbox"/> Yes	Infectious disease e.g. HIV	<input type="checkbox"/> Yes
Gastrointestinal/liver disorder	<input type="checkbox"/> Yes	Current malignancy	<input type="checkbox"/> Yes
Renal Disorder	<input type="checkbox"/> Yes	Previous chemotherapy	<input type="checkbox"/> Yes
Neurological Disorder e.g. epilepsy	<input type="checkbox"/> Yes	Uterine anomalies/fibroids	<input type="checkbox"/> Yes
Rheumatologic Disorder e.g. SLE	<input type="checkbox"/> Yes	Uterine / cervical surgery e.g. cone biopsy / LLETZ procedure	<input type="checkbox"/> Yes

Medications (including vitamins and supplements):

_____	_____
_____	_____
_____	_____

Allergies:

Other relevant information:

Doctors signature: _____

Date: _____

Appointment details will be sent to referring GP and patient.

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