Mater
Health Services Brisbane Limited

REFERRAL TO MATER CENTRE FOR MATERNAL FETAL MEDICINE (MFM) FAX: 3163 1890

Unit Record No.	
Surname	
Given Names	
Date of Birth	Sex
	AFFIX PATIENT IDENTIFICATION LABEL HERE

weeks

REFERRAL TO MATER CENTRE FOR MATERNAL FETAL MEDICINE

WORLD RECOGNISED
ACCREDITATION

Urgent - phor	ne 3163 1896 or A/ŀ	l on 3163 8111			
Patient details					
Residential address					
Suburb	State	Postal code			
Home phone no.	Mobile phone	Mobile phone no.			
Interpreter required: Yes No Language					
Is the patient of Aboriginal or Torres Strait Islander of	origin: Yes, Aboriginal	Yes, Torres Strait Islander	No	Unknown	
Medicare eligible: Yes No Private hea	Ilth insurance: Yes	No			
Referral to Dr Glenn Gardener MBBS, DipRACOG, FRANZCOG, CI Dr Joseph Thomas MBBS, FRANZCOG, CMFM, DDU Dr Scott Petersen MBBS, FRANZCOG, CMFM Prof Sailesh Kumar MBBS M.MED (0&G) FRCS FRCOG ASSOC. Prof Rob Cincotta MBBS, FRANZCOG, DDU, Dr Jackie Chua MBBS, FRANZCOG, DDU, COGU	G FRANZCOG DPhil (Oxon) CMF	М			
Patient information					
EDB					

Service requested 1st Trimester/ Nuchal translucency 11 - 13 weeks Multiple pregnancy assessment Cervical length Morphology scan 18 - 20 weeks Placental assessment Tertiary scan Fetal growth and wellbeing Consultation only

Clinical history/ Indication for referral

At what gestation would you like your patient to be seen?

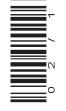
Please provide copies of any previous scans

Referring doctor

Other

Date of referral	Provider number			
Referring clinician name				
Address				
Obstetric specialist	Queensland Health hospital/ facility General Practitioner		ctitioner	with O&G Diploma
Phone number	Results to be:	Faxed	Posted	
Fax number	Referring clinician signature			
Consultant name	1 1011401 1141	mber		NAT

Your doctor has recommended that you use Mater Centre for Maternal Fetal Medicine. You may choose another provider but please discuss this with your doctor first.



02/16 Ver. 3.00 F2000