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

☐ **Urgent - phone 3163 1896 or A/H on 3163 8111**

Patient details

Residential address .....

Suburb ..... State - ..... Postal code .....

Home phone no. ..... Mobile phone no. .....

Interpreter required: ☐ Yes ☐ No Language .....

Is the patient of Aboriginal or Torres Strait Islander origin: ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ No ☐ Unknown

Medicare eligible: ☐ Yes ☐ No **Private health insurance:** ☐ Yes ☐ No

Referral to

☐ **Dr Glenn Gardener** MBBS, DipRACOG, FRANZCOG, CMFM
☐ **Dr Joseph Thomas** MBBS, FRANZCOG, CMFM, DDU
☐ **Dr Scott Petersen** MBBS, FRANZCOG, CMFM
☐ **Prof Sailesh Kumar** MBBS M.MED (O&G) FRCS FRCOG FRANZCOG DPhil (Oxon) CMFM
☐ **Assoc. Prof Rob Cincotta** MBBS, FRANZCOG, DDU, CMFM
☐ **Dr Jackie Chua** MBBS, FRANZCOG, DDU, COGU

Patient information

EDB .....

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

Service requested

☐ 1st Trimester/ Nuchal translucency 11 - 13 weeks
☐ Morphology scan 18 - 20 weeks
☐ Tertiary scan
☐ Fetal growth and wellbeing
☐ Other .....

☐ Multiple pregnancy assessment
☐ Cervical length
☐ Placental assessment
☐ Consultation only

Clinical history/ Indication for referral

Please provide copies of any previous scans

Referring doctor

Date of referral ..... Provider number .....

Referring clinician name .....

Address .....

☐ Obstetric specialist ☐ Queensland Health hospital/ facility ☐ General Practitioner ☐ with O&G Diploma

Phone number ..... **Results to be:** ☐ Faxed ☐ Posted .....

Fax number ..... Referring clinician signature .....

Consultant name ..... Provider number .....

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.

NATA
WORLD RECOGNISED ACCREDITATION

02/16
Ver. 3.00
F2000

CLEAR FORM

PRINT FORM

REFERRAL TO MATER CENTRE FOR MATERNAL FETAL MEDICINE 100