ANTENATAL REFERRAL

Fax number: (07) 3163 8053

Unit Record No. ____________________

Surname ____________________

Given Names ____________________

DOB ____________ Sex ____________

AFFIX PATIENT IDENTIFICATION LABEL HERE

F1828

Patient Details

Surname:		Given name(s):		
Date of birth:	Home phone number:	Mobile phone number:	Email address:	
Address:		Suburb:	State:	Postcode:
Next-of-kin:		Contact number:		

Medicare eligible: ☐ Yes ☐ No	Medicare number:	Reference:	Expiry date:

Please advise all patients to bring their Medicare card when presenting to the Mater. Medicare ineligible patients will incur a fee for appointments/ treatment provided which is payable on presentation. Insurance provider and policy number must be provided before bookings can be processed.

Private health insurance: ☐ Yes ☐ No	Fund name:	Policy number:

Is the patient of Aboriginal or Torres Strait Islander origin:
☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ Yes, both Aboriginal and Torres Strait Islander ☐ No ☐ Not stated/unknown

Will the baby identify as Aboriginal or Torres Strait Islander: ☐ Yes ☐ No

Interpreter required: ☐ Yes ☐ No	Language:	Is the patient of refugee background: ☐ Yes ☐ No

Special cares (e.g. carer):

Referral

This referral is for an initial consultation with a Doctor for the planning and co-ordination of care for this pregnancy. Women will be subsequently offered a choice of appropriate models of care. To improve efficiency and reduce waiting times, this named referral will be shared with other specialists. The consultation may be bulk-billed to Medicare Australia with NO out of pocket expenses for this patient.

Attention: **Dr. Sarah Janssens** (Director Obstetrics & Gynaecology)	Referral date:

Thank you for seeing this patient. Please see below for referral details.

LNMP:	EDC:	Gravida:	Parity:	Weight (kg):	Height (cm):	BMI:

This patient is high risk and requires early assessment: ☐ Yes ☐ No

High risk pregnancy details:

Past genetic, medical, surgical, and obstetric history:

Binding margin - do not write. Do not reproduce by photocopying.
All clinical form creation and amendments must be conducted through Health Records.

09/24
Ver. 9.00
F1828

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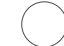
Allergies

Name of medication/food/other	Description of previous reaction

Current Medications

Medication name	Strength	Dose	Medication name	Strength	Dose



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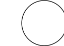

Models of Care

Preferred model of care if available:

GP Shared Care: ☐ Yes ☐ No | I have completed the *MMH* alignment program: ☐ Yes ☐ No

I have completed an alignment program with the following hospital: | Date completed:

Midwifery care: ☐ Yes ☐ No | Midwifery Group Practice: ☐ Yes ☐ No

Relevant Investigations (attach investigations or results)

Pathology service provider: ☐ Mater Pathology ☐ S&N ☐ QML ☐ Other *(specify)*: ....

Pap smear or cervical screening:	☐ Yes ☐ No	Results: ☐ Normal ☐ Abnormal
Screening for fetal anomalies discussed:	☐ Yes ☐ No	Testing accepted: ☐ Yes ☐ No
Referral given:	☐ Yes ☐ No	
First trimester HBA1c for BMI >30, previous GDM, maternal age >40, PCOS or previous macrosomic baby:	☐ Yes ☐ No	HIV: ☐ Yes ☐ No
18/40 morphology ultrasound ordered:	☐ Yes ☐ No	Syphilis serology: ☐ Yes ☐ No
FBC:	☐ Yes ☐ No	Blood group and antibody: ☐ Yes ☐ No
Rubella serology:	☐ Yes ☐ No	Hepatitis B serology: ☐ Yes ☐ No
Urine M/C/S:	☐ Yes ☐ No	Hepatitis C serology: ☐ Yes ☐ No

Referring Doctor's Details (please complete all fields clearly or affix stamp)

Doctor's name:		Provider number:	
Practice address:		Suburb:	State: / Postcode:
Phone number:	Fax number:	Email address:	Signature:

Mater Staff Use Only

Date received:	Age:	EDC:	Current gestation:

☐ Referral accepted ☐ Referral declined ☐ Other *(specify)*: .... ☐ Out of area

☐ GP notified Date notified: .... ☐ Woman notified – Date notified: ....

☐ First appointment midwife and obstetrician | ☐ Woman notified of date of first appointment: ....

☐ Medicare eligible ☐ Medicare ineligible AND insured ☐ Medicare ineligible and NOT insured | Date sent to billing office:

Notes:

Midwife (print name): | Signature: | Date:

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