Mater Misericordiae Ltd

REFERRAL - ANTENATAL

FAX NUMBER: (07) 3163 8053

MHS Unit Record No. _____

Patient surname _____

Patient given names _____

Patient date of birth _____

Do not fax from private or business numbers. GP fax only.

Patient details

Residential address:

Suburb: State: Postal code:

Preferred contact: ☐ Home ☎: ☐ Mobile ☎:

Next of kin: ☎:

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.

Medicare eligible? ☐ Yes ☐ No Medicare no.: Card ref. no.: Expiry date:

Private health insurance name: Policy number:

Indigenous status? ☐ Aboriginal ☐ Torres Strait Islander ☐ Australian South Sea Islander ☐ Not Indigenous

Does this patient identify as having a refugee background? ☐ Yes ☐ No

Interpreter required? ☐ Yes ☐ No Language: **Special needs** e.g. Carer:

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.

Referral

Referral date:

Dear Dr Michael Beckmann (Director, Mothers Babies and Women's Health Services)

Thank you for seeing this woman whose LNMP was and whose EDC is

She is **G** **P** **Height** **Weight** **BMI**

This patient is high risk and requires early assessment ? ☐ Yes ☐ No If "Yes", specify details below

Past genetic, medical ,surgical, and obstetric history:

F1828 06/16
06/16
Ver. 6.00
F1828

Clear form

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Medications: (attach patient summary if necessary)

Allergies:

Models of care

I have discussed models of care and this woman would like:

GP Shared Care? ☐ Yes ☐ No

I have completed the MMH alignment program: ☐ Yes ☐ No.

Midwifery Care? ☐ Yes ☐ No

Midwifery Group Practice? ☐ Yes ☐ No Second choice if **Midwifery Group Practice** full?

Relevant investigations (attach investigations or results)

Pathology service provider: ☐ Mater ☐ S & N ☐ QML

1. **Pap smear up to date?** ☐ Yes ☐ No
   Result: ☐ Normal ☐ Abnormal
2. **Down Syndrome screening discussed?** ☐ Yes ☐ No
   Testing accepted? ☐ Yes ☐ No
   Referral given? ☐ Yes ☐ No
3. **First trimester HbA1c for BMI > 30, previous GDM, maternal age ≥ 40, or previous macrosomic baby?** ☐ Yes ☐ No
4. **18/40 morphology ultrasound ordered?** ☐ Yes ☐ No
6. **FBC?** ☐ Yes ☐ No
7. **Rubella serology?** ☐ Yes ☐ No
8. **Urine M/C/S?** ☐ Yes ☐ No
9. **HIV?** ☐ Yes ☐ No
10. **Syphilis serology?** ☐ Yes ☐ No
12. **Blood group & antibody?** ☐ Yes ☐ No
13. **Hepatitis B serology?** ☐ Yes ☐ No
14. **Hepatitis C serology:** ☐ Yes ☐ No

Referring clinician (Please complete all fields clearly or affix stamp)

Referring clinician name: Provider number:

Address:

Phone number: Fax number:

Signature: Email address:

Mater staff use only

Date received:

☐ **Referral accepted** Age: EDC: Current gestation:

☐ **Referral declined** ☐ Out of Area ☐ Other

☐ GP Notified Date sent: ☐ Woman notified Date notified:

☐ **First appointment midwife and obstetrician** ☐ Woman notified of first appointment on

☐ **Medicare eligilbe** ☐ Medicare ineligible AND insured ☐ Medicare ineligible, NOT insured

Sent to billing office date: Sent to billing office date:

Notes:

Midwife name: **Signature:** **Date:**

Print form