**Maternity Referral Form**

**The Royal Women’s Hospital**

**Fax referral to: 8345 3036**

Dear Dr

As the Women’s hospital health services operate mixed outpatient clinics, we request all referrals be addressed to a named medical practitioner. This enables us to provide patients with the choice of being treated as either a private or a public patient.

**Patient Details**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| First Name | |  | | | | Last Name |  | Previous RWH patient | |  Yes  No | | | |
| Date of Birth | | |  | | | | | Medicare Number |  | | Exp. Date |  | |
| Address | | | | | | | | Health Insurance Fund | |  Yes  No | | | |
| Suburb |  | | | | | Postcode |  | ATSI | |  Yes  No | | | |
| Home Phone | |  | | | Mobile | |  | Disability or special needs | |  Yes  No | | | Specify |
| Interpreter required? | | | |  Yes  No | | | | Language (please specify) | | | | | |
| Country of birth | | | | | | | |  | | | | | |

**Referring Doctor**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Print Name | |  | | | | | Provider Number | |  | |
| Practice Address | | | | Suburb | | | | Postcode | |  |
| Phone |  | | Fax | |  |

**Would like to participate in shared care if eligible:** Yes

|  |
| --- |
| **Need for tertiary obstetric care?**   Yes No *Provide details \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Need for hospital assessment before 16 weeks gestation?** Yes No *Provide details \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Aspirin started** Yes  (Commence aspirin 150 mg nocte orally in the first trimester if previous preeclampsia. Do not wait for hospital review) |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Current Obstetric History** | | | | | | | | | | | | | |
| **LNMP:** | |  | | |  | | | Estimated delivery date\*: |  | | | | |
| **Gravida:** | | |  | **Parity:** | |  | | **Known multiple pregnancy:** | | Yes No     | | | |
| **Height:** | | cm | | **Weight:** | | kg | | Fetal abnormality (known/concerns). | | | Yes No |
| BMI\*: | <18.5, 18.5 - 35, If > 35 (please indicate ……..) | | | | | | **BP**: | | | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Alcohol | ❒ Yes | Iodine supplementation | ❒ Yes | Flu vaccine this pregnancy | ❒ Yes |
| Smoked in last 12 months | ❒ Yes | 1st trimester folate | ❒ Yes | COVID immunised (both doses) | ❒ Yes |
| Illicit drugs | ❒ Yes |

**Past Medical and Surgical History**

**Past or present mental health issues**

**Social History**

**Past Obstetric History**

❑ Not applicable - primigravida ❑ Not applicable - no significant complications

|  |  |  |  |
| --- | --- | --- | --- |
| Previous stillbirth | ❑Yes | Gestational Diabetes | ❑Yes |
| Previous fetal abnormality (specify) | ❑Yes | Previous pre-eclampsia/HELLP | ❑Yes |
| Mid trimester loss OR miscarriage x3 or more | ❑Yes | Obstetric Cholestasis | ❑Yes |
| Preterm birth <37/40 (gestation) \_\_\_\_\_\_\_ | ❑Yes | Maternal red cell antibodies | ❑Yes |
| IUGR or <2800g at term | ❑Yes | PPH >1000mls | ❑Yes |
| Large baby > 4500g at term | ❑Yes | Previous Neonatal Alloimmune Thrombocytopenia | ❑Yes |
| Cervical cerclage | ❑Yes | Perinatal psychosis | ❑Yes |
| Placenta l abnormalities/abruption | ❑Yes | Previous caesarean | ❑Yes |
| Other: |  |  |  |

**Risk factors relevant to pregnancy**

❑ Not applicable - no relevant risk factors

|  |  |  |  |
| --- | --- | --- | --- |
| Alcohol and other drugs (specify) | ❑Yes | Diabetes pre-pregnancy | ❑Yes |
| Psychiatric disorders | ❑Yes | Other endocrine disorder (specify) | ❑Yes |
| Family history of genetic disease/anomalies (specify) | ❑Yes | Thalassaemia | ❑Yes |
| Heart Disease | ❑Yes | Haematological/Coagulation disorder e.g. sickle cell | ❑Yes |
| Hypertension | ❑Yes | Hep B carrier or Hep C | ❑Yes |
| Respiratory Disease (including severe asthma) | ❑Yes | Infectious disease e.g. HIV | ❑Yes |
| Gastrointestinal/liver Disease | ❑Yes | Current malignancy | ❑Yes |
| Renal Disease | ❑Yes | Previous chemotherapy | ❑Yes |
| Neurological Disease e.g. epilepsy | ❑Yes | Uterine anomalies/fibroids | ❑Yes |
| Rheumatologic Disease e.g. SLE | ❑Yes | Uterine/cervical surgery e.g. cone biopsy/LLETZ procedure | ❑Yes |

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Investigations: Please attach results if available or fax on 03 8345 2623 when available**

*If you are ordering tests for a patient (or potential patient) of the Women’s, PLEASE add RWH in the cc box on your pathology request. This will enable electronic transfer of results to the women’s electronic medical record. If the patient has not previously attended the RWH (eg this is a new referral) please also attach pathology and ultrasound results to this referral prior to faxing*

**Pathology Provider\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Radiology Provider\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Routine tests**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| FBE | ❑ | Rubella | | | ❑ | | Hepatitis C | | | ❑ |
| Blood group and antibodies | ❑ | HIV serology | | | ❑ | | Syphilis serology | | | ❑ |
| Ferritin | ❑ | Hepatitis B carrier | | | ❑ | | MSU / urinalysis | | | ❑ |
| 12 week Ultrasound (Nuchal translucency, number and dating) | | | | | | ❑ | | | | |
| **Morphology Ultrasound (20-22 weeks)** ❑  ***Please note:*** *Not routinely available at the hospital and most women will need to have these ordered by their GP* | | | | | | | | | | |
| **Tests to consider** | | | | | | | | | | |
| Fasting glucose & HbA1c (if high risk of developing GDM) | | | ❑ | Thalassemia test | | | | ❑ | Varicella Ab | ❑ |
| Early ultrasound (eg at 8 weeks if dates uncertain or concerns regarding viability) | | | ❑ | TSH | | | | ❑ | Chlamydia | ❑ |
|  | | |  |  | | | |  |  |  |

**Aneuploidy testing** *Aneuploidy testing should be discussed and offered to all women irrespective of age.*

Patient has decided to have aneuploidy testing ❑ Yes ❑ No

**If yes:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| First Trimester Combined Screen  or | completed | ❑ | ordered | ❑ | Provider |
| NIPT (high risk of aneuploidy or primary screen)  or | completed | ❑ | ordered | ❑ | Provider |
| Second Trimester MSST | completed | ❑ | ordered | ❑ | Provider |
| If high risk aneuploidy screening result consider CVS/Amniocentesis | completed | ❑ | ordered | ❑ | Provider |
| Reason\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |

**Medicines**

**Allergies**

**Other relevant information**

**Investigations**

|  |  |  |  |
| --- | --- | --- | --- |
| **Doctor’s signature:** |  | **Date:** |  |

**Appointment details will be sent to referring GP and patient.**

Referrals are triaged by a clinician based on the patient’s residential address proximity to the Women’s and the anticipated need for tertiary level care

Guidance in assessing, managing and referring some problems can be found on the <https://www.thewomens.org.au/wm-scguide> and <https://melbourne.healthpathways.org.au>

Please encourage your patient to link to My Health Record as it has a capability to upload pathology & imaging reports [https://myhealthrecord.gov.au/internet/mhr/publishing.nsf/Content/appconnect](https://protect-au.mimecast.com/s/kq_5Clx1XNI2gmlLFN9IU1?domain=myhealthrecord.gov.au)