**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 public patient.

**Patient Details**

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

Referring Doctor

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

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

|  |
| --- |
| **Need for tertiary obstetric care?**   Yes No *Provide details below* |
| **Need for hospital assessment before 16 weeks gestation?** Yes No *Provide details below* |
| **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 ……..) |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 1st trimester folate | ❒ Yes  | Iodine supplementation | ❒ Yes  | Flu vaccine this pregnancy | ❒ Yes  |
| Smoked in last 12 months | ❒ Yes  | Alcohol | ❒ 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 relevant past obstetric

|  |  |  |  |
| --- | --- | --- | --- |
| Previous stillbirth  | ❑Yes  | Gestational Diabetes | ❑Yes  |
| Previous fetal abnormality (specify) | ❑Yes  | Previous severe 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  |
| Cervical cerclage  | ❑Yes  | Previous Neonatal Alloimmune Thrombocytopenia | ❑Yes  |
| Placenta l abnormalities/abruption | ❑Yes  | Perinatal psychosis | ❑Yes  |
| Previous caesarean  | ❑Yes Number\_\_\_  | 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: Attach relevant. If not available, fax to The Women’s on 03 8345 2623 when available**

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

**Routine tests**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| FBE | ❑ | Rubella  | ❑ | Hepatitis C | ❑ |
| Blood group and antibodies | ❑ | HIV serology  | ❑ | Syphilis serology  | ❑ |
| Ferritin  | ❑ | Hepatitis B carrier  | ❑ | MSU / urinalysis  | ❑ |
| **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** |
| Early GTT  | ❑ | Thalassemia test | ❑ | Varicella Ab | ❑ |
| Dating ultrasound (eg at 12 weeks)  | ❑  | Vitamin D | ❑  | Chlamydia | ❑  |
| TSH | ❑ |  |  |  |  |

**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 + 12 weeks nuchal translucency  or | completed | ❑ | ordered | ❑ | Provider |
| Second Trimester MSST + 12 weeks nuchal translucency   | completed | ❑ | ordered | ❑ | Provider |
| If high risk, CVS/Amniocentesis | completed | ❑ | ordered | ❑ | Provider |
| Reason\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Medicines**

**Allergies**

**Other relevant information**

|  |  |  |  |
| --- | --- | --- | --- |
| **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 is 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 their https://myhealthrecord.gov.au/internet/mhr/publishing.nsf/Content/appconnectvia a phone app as its capability to upload pathology & imaging reports is increasing