Referral Form – Obstetrics and Midwifery

Women’s and Children’s Health Network
72 King William Road, North Adelaide SA 5006 Tel: 08 8161 7000

Public Patient Fax: 08 8161 6246 Private Patients Fax: 08 8161 7654

Please complete this form in conjunction with the Obstetric and Midwifery referral guidelines. If referring to the Private Consulting Suite please provide Named referral – see Profiles Page Link

*Note this is Not a MFM Referral Form*

Dear, ____________________________________ Request Private Patient ☐ Public Patient ☐

### Client details

- **Surname** ______________________________________________________________________________________________
- **First Name** ____________________________________ **Middle Name/s** ___________________________________
- **Date of Birth** ____/____/________ **WCH UR** (if known) ___________________
- **Address** ______________________________________________________________________________________________
- **Suburb** ____________________________________ **Postcode** ________
- **Ph Home** ________________________ **Work** ________________________ **Mobile** ________________________
- **Next of Kin** ____________________________________ **Medicare Number** ___________________________________

- **Is the client of Aboriginal or Torres Strait Islander origin?**
  - ☐ No
  - ☐ Yes, Aboriginal
  - ☐ Yes, Torres Strait Islander
  - ☐ Yes, Aboriginal & Torres Strait Islander

- **Is an interpreter required?**
  - ☐ No
  - ☐ Yes If yes, please state language ___________________________________

- **Is this client under the Guardianship of the Minister?**
  - ☐ No
  - ☐ Yes

### Referral Information

#### Current Obstetric History

- **Pregnancy Reference Number:**_______________  **LMP**______________ **Gravida**______________ **Parity**______________

- **Height**________  **Weight:**________  **BMI:**________  **Last PAP smear**(date/result) ______________

- **IVF Pregnancy** ☐ No  ☐ Yes  **Female Circumcision** ☐ No  ☐ Yes

- **Investigations ordered**
  - [ ] Blood group and antibodies
  - [ ] Hep B+C
  - [ ] Down Syndrome screening
  - [ ] HIV serology
  - [ ] Dating U/S
  - [ ] Syphilis
  - [ ] Vitamin D for at risk Women
  - [ ] Morphology Scan (18-20weeks)
  - [ ] Rubella
  - [ ] MSSU

Please provide detailed information and forward any pathology and x-ray reports that will assist us to determine the priority assigned to the client.

Last Updated: 7/7/2016
### Past Obstetric History

<table>
<thead>
<tr>
<th>Flags</th>
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<tbody>
<tr>
<td>☐ Pre-eclampsia</td>
</tr>
<tr>
<td>☐ Still Birth</td>
</tr>
<tr>
<td>☐ Foetal abnormality</td>
</tr>
<tr>
<td>☐ Preterm Birth</td>
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</tbody>
</table>

*Please provide detailed information on Clinical history that will assist us to determine the priority assigned to the client*

### Past Medical / Surgical / Psychiatric / Social History

<table>
<thead>
<tr>
<th>Flags</th>
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<tbody>
<tr>
<td>☐ Diabetes</td>
</tr>
<tr>
<td>☐ Epilepsy</td>
</tr>
<tr>
<td>☐ DVT/pulmonary embolus</td>
</tr>
<tr>
<td>☐ Renal disease</td>
</tr>
<tr>
<td>☐ SLE</td>
</tr>
<tr>
<td>☐ Alcohol and other drugs</td>
</tr>
</tbody>
</table>

*Please provide detailed information on Clinical history that will assist us to determine the priority assigned to the client include all current medications, relevant allergies and immunisations*

### Referring Clinic Details

**Referring Doctor Name** ____________________________  **Provider No.** ____________________________

**Surgery Name** ____________________________________________  **Contact No.** ____________________________

**Address** ____________________________________________  **Suburb** ____________________________  **Postcode** ____________________________

**Signature** ____________________________________________  **Date** ____________________________

*Completed, signed & dated forms fax PUBLIC to WCH Administration Hub on 8161 6246
PRIVATE to Private Consulting Suite on 8161 7654*

### WCH Office Use

<table>
<thead>
<tr>
<th>UR NO:</th>
<th>CLINIC</th>
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</thead>
<tbody>
<tr>
<td>CONSULTANT</td>
<td>DATE</td>
</tr>
<tr>
<td>TRIAGE CATEGORY</td>
<td>BY</td>
</tr>
</tbody>
</table>