

Maternity Referral Form

Patient details:

First Name: _____

Surname: _____

Date of Birth: _____

Address: _____

Mobile No.: _____

Home No.: _____

Medicare No.: _____

Country of Birth: _____

ATSI _____

Gravida:	Para:
_____	_____
LNMP:	EDD:
_____	_____
Height:	Weight:
_____	_____
BMI:	

Referring Practitioner details:

Office Stamp:

Medical History

- Anaesthetic** difficulties
- Diabetes** before being pregnant
- Cardiac Disease** (significant)
- Current **illicit drug** use or **methadone/buprenorphine**
- Asthma** (hospitalised in last 12 months)
- Haematological disorders**, anaemia or DVT clots
- Epilepsy** (on medication)
- Hypertension** (list medication below or attach)
- Multiple** pregnancy
- On **medications** (list medication below or attach)
- 28 weeks** with no antenatal care
- Rare** or **severe** problems
- Thyroid disease** (uncontrolled)

Previous Pregnancies

- 3** or more pregnancies
- Fits** in pregnancy or labour
- Rhesus isoimmunisation**
- Parity > **5 babies**
- Severe **pre-eclampsia**
- Other significant** maternity problems
- Shoulder dystocia**
- Large baby** > 4500g
- Small baby** < 2500g
- Significant **PPH** ≥ 1000mLs
- One** caesarean birth
- Multiple** caesarean births

Additional information

Additional information attached

The following tests have been requested:

- Blood Gp & Antibodies
- HepBsAg
- FBE
- Hep C
- Hb electrophoresis
- Chlamydia
- Ferritin
- Dating ultrasound
- MSU – m/c/s

- TPHA
- Morphology ultrasound
- Aneuploidy screening
- Pap test
- OGTT (if risk factors e.g.: GDM)
- HIV ab
- Rubella IgG
- Random serum glucose

Statewide Referral Criteria that require further information:

- [Congenital anomalies](#)
- [Fetal growth restriction](#)
- [Maternal isoimmunisation](#)
- [Maternal medical conditions](#)
- [Multiple gestation](#)
- [Obesity](#)
- [Placenta accreta](#)
- [Pre-eclampsia](#)
- [Shortened cervix](#)
- [Type 1 diabetes \(Obstetrics\)](#)