NSW GOVERNMENT Health
South Eastern Sydney Local Health District

Facility: The Royal Hospital for Women

ANTENATAL REFERRAL

FAMILY NAME MRN

GIVEN NAME ☐ MALE ☐ FEMALE

D.O.B. ____/____/____ M.O.

ADDRESS

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

SES060409

GP STAMP:

Fax No:
Ph. No:
Provider No:

THIS WOMAN IS TO RETURN TO ME FOR SHARED CARE?
☐Yes ☐No

GP Signature: _____

Date:___/___/_____

When offering first trimester screening for Aneuploidy, please counsel and organise before 13 weeks gestation.

Consultants: Dr Coogan, Dr Fay, Dr Horrowitz, Dr Lee

NAME_____ **Age** _____

L.M.P _____ **Regular / Irregular**_____

E.D.C _____

Gravida _____**Para** ____**Miscarriage** _____

CURRENT PREGNANCY: (tick if present)

☐Nausea / vomiting
☐PV bleeding
☐Abdominal pain
Current Medications_____

_____

☐Folic Acid ☐Iodine

Cigarettes - number per day _____

Alcohol - gm / week _____

Allergies_____

PREVIOUS OBSTETRIC HISTORY:

Year of Birth	Gestation	Birth Weight	Pregnancy Issues	Type of Birth	Postnatal Issues

FAMILY HISTORY: (tick if present)

☐Cardiac ☐Bleeding issues
☐Diabetes ☐Mental Health
☐Hypertension
☐Congenital abnormalities Specify_____

EXAMINATION:

BP___/___ at ___ weeks gestation

Abdomen _____ Heart_____

Lungs _____ Thyroid_____

Breast examination_____

BMI _____

Other findings:

MEDICAL HISTORY: (tick if present)

☐Hypertension
☐Endocrine:
☐Diabetes
☐Thyroid
☐PCOS
☐Other: _____
☐Infertility/IVF
☐Endometriosis
☐Sexually Transmitted Infections
☐Hepatitis: Specify _____
☐Cardiac
☐Asthma
☐Renal
☐Epilepsy
☐Transfusions
☐Mental Health:
Specify _____
☐Depression / Anxiety

Other past History_____

_____

Previous surgery (especially uterine) _____

SOCIAL HISTORY: _____

_____

RESULTS

Please ensure the following results are available:
(and a copy given to your patient)

Blood group & antibody screen
Full blood count
Haemoglobin EPG
(as per hospital guidelines)
Rubella IgG
Syphilis (ELISA)
Hepatitis B (surface antigen)
Hepatitis C
HIV
MSU for M/C/S

Cervical Screening Test
High Risk results ☐Yes ☐No
HPV Date _____
LBC Date _____ Result _____

Prenatal Diagnosis arranged ☐Yes ☐Declined
If yes, then type arranged ☐NT Plus ☐Other
Specify _____

Genetic counselling arranged ☐Yes ☐No
Morphology ultrasound booked ☐Yes ☐No

Holes punched as per AS2828-2012
BINDING MARGIN - NO WRITING

ANTENATAL REFERRAL
SES060.409

S0741 130819

NO WRITING

Health
South Eastern Sydney
Local Health District

Facility: The Royal Hospital for Women

ANTENATAL REFERRAL

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____ / _____ / _____	M.O.
ADDRESS	
LOCATION / WARD	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

WOMAN TO COMPLETE THIS SECTION

Family Name:	Given Names:
Previous/Family Name:	Previous/Family Name:
Date of Birth:	Medicare card #: __ __ __ __ __ __ __ __ __ __ / __ Exp date:

Marital status: ☐ **De Facto** ☐ **Divorced** ☐ **Married** ☐ **Never married** ☐ **Separated** ☐ **Widowed** ☐ **Declined to respond** ☐ **Unknown**

Country of Birth:	Religion:
Language used at home:	Interpreter needed: ☐ **Yes** ☐ **No**

Are you Australian Aboriginal? ☐ **Yes** ☐ **No** Are you Torres Strait Islander? ☐ **Yes** ☐ **No**
Is the father of the baby Australian Aboriginal? ☐ **Yes** ☐ **No** Is the father of the baby Torres Strait Islander? ☐ **Yes** ☐ **No**

Private insurance: ☐ **Yes** ☐ **No** **Fund Name:** **Fund No:**

Billing Status: ☐ **Overseas (no Medicare)** ☐ **Reciprocal** ☐ **Medicare**

Home Address		**Person to Contact**	
Street:		Name:	
		Relationship:	
Suburb:		Street:	
State:	P/code:	Suburb:	
Phone no: (h)		State:	P/code:
(w) (Mob)		Phone no:	
Have you attended this Hospital before?		☐ Yes ☐ No If yes, under what family name?	

Have you previously received pregnancy care at the Royal Hospital for Women ☐ **Yes** ☐ **No**

Would you like Shared Pregnancy Care with your GP & the hospital? ☐ **Yes** ☐ **No**
(Shared Care involves alternating visits with your GP and the Hospital clinics)

Would you like Midwifery Group Practice? (a waiting list usually applies) ☐ **Yes** ☐ **No**

What is your preferred appointment time for your hospital pregnancy care? ☐ **am** ☐ **pm**

I agree that my personal health information may be shared between my GP and the hospital.

Name _____ **Signature** _____ **Date:** __/__/_____

PLEASE BRING THIS COMPLETED FORM TO YOUR FIRST ANTENATAL/BOOKING IN APPOINTMENT AT THE ROYAL HOSPITAL FOR WOMEN

NO WRITING