

ANTENATAL THYROID CLINIC REFERRAL FORM

REFERRAL CRITERIA

- TSH ≥4mIU/L;
- TSH <0.01 (i.e. suppressed TSH);
 Current or past history of Graves' disease;
- Thyroid **nodule**.

ALL FIELDS MUST BE COMPLETED OR THE FORM WILL BE RETURNED

Prior to referral please review the Thyroid Disease in Pregnancy Guidelines at https://www.cesphn.org.au/documents/antenatal-shared-care-1/gp-resources/2137-thyroid-anc-gp-flowchart-june-2018-v2 for guidance on further blood tests that may be required prior to our clinic review

	То:		ıtal Thy	roid Cli			crine Unit P: 95157225)							
	Dear Dr	Gargya	ι,											
	Re:	DOB RPA MRN (if known)												
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						1								
4. [W	еек	s pregnant EI	Ю						
	She presents with Hypothyroidism					B. ☐ Hyperthyroidism C. ☐ Current or past								
	□ new □ existing					□ new □ existing history of Graves 'Disease								
	Date		_		ld		Date Bloo	_		Gra	ves Disease			
	TSH						TSH							
	fT4		-				fT4f	Т3						
	TPO AbTg Ab						TSH receptor Ab	}						
-	Thyroxi	ne	ne Dose Start Date				□ Anti Thyroid Mo	edication Dose						
	Current	ıt				□ Propylthiouracil □ Thyroid D. Nodule								
	Pre pregnanc	v					□ Carbimazole				1,00010			
	□ Not commenced				1									
	Previous thyroid surgery													
	Can you please assess need for ongoin Yours sincerely,							and advise.				П	Ante l	Natal Clinic
		()				print) ph							ive's Clinic	
	Signature						Date						Birth	Centre
					Fa	x fo	orm ONLY: 951				nic will contact the			ge an appointment
	<u>T</u>	≥ Triage to R/V by Bookin			-	Requested Date				Blood Test	<u>eMR</u>	entry ?	Booking Completed	
	99	Medical Nursing	□ Endo	-	□ 1 wl			□ 2 wks		4 wks	□ Attached	Yes_		□ Booked
	Office	Turomg		Reg 2		□ N/A			□ N/A	No_		□ Posted		
	-		-		Actual	Date	Time	_						□ Collected