REFERRAL & ANTENATAL BOOKING FORM

St George / Sutherland Hospitals and Health Services
South Eastern Sydney Local Health District

Information about your health and wellbeing will be collected and be available to both the hospital and your GP unless otherwise requested.

Patient to complete this section	Phone ASAP for appointment or book online by searching for 'Sutherland antenatal appointment form' or 'St George antenatal appointment form'

Surname:		**Given Names:**
Previous/Maiden Name:		**Occupation:**
Marital status:		
Date of Birth:	**Country of Birth:**	**Religion:**
Language spoken at home:		**Interpreter needed?** Yes ☐ No ☐
Will the baby be Aboriginal? Yes ☐ No ☐		**Will the baby be Torres Strait Islander:** Yes ☐ No ☐
Pre-pregnancy weight: Kg		**Height:** cm
Home Address		**Next of Kin**
Street:		**Name:**
		Relationship:
Suburb:		**Street:**
State: P/Code:		**Suburb:**
Phone no (H):		**State: P/Code:**
(w) (Mob)		**Phone no:**
E-mail address:		
Medicare Eligibility**:** Overseas (no medicare) ☐ Reciprocal ☐ Medicare ☐		
Medicare card no:		**Exp date:**
Health Fund: Yes ☐ No ☐	Fund name**:** No Insurance	Policy no:
Insured for pregnancy related services: Yes ☐ No ☐ Not sure ☐		
Are you aware of the obstetric private billing arrangement: Yes ☐ No ☐		

Have you previously attended St George Hospital before?	Yes ☐ No ☐
Have you previously attended Sutherland Hospital before?	Yes ☐ No ☐
If yes, under what surname?	

Have you previously received pregnancy care at St George **(** ☐ **)** or Sutherland **(** ☐ **)** Hospitals?
If so, which clinic did you attend? _____

Would you like the same care for this pregnancy?	Yes ☐ No ☐

(The options below is low risk pregnancy)

Are you interested in the St George Birth Centre for your pregnancy care?	Yes ☐ No ☐

To book your appointment, phone (02) 9113 2162

or book online by searching for 'Sutherland antenatal appointment form' or 'St George antenatal appointment form'

OTHER USEFUL PHONE NUMBERS

St George Hospital	
Main Switchboard	9113 1111
Sutherland Hospital	
Main Switchboard	9540 7111
Interpreter Service	131 450

Please **bring** this completed form with you when you attend your **first** antenatal appointment.

The location of your appointment will be advised on your appointment confirmation letter.

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GP Name _____
Practice name _____
Practice Address _____
Fax: _____
Ph: _____
Provider no: _____

THIS WOMAN IS SUITABLE AND INTERESTED IN SHARED CARE?

Yes ☐ No ☐

GP Signature _____

Date: _____

I wish to share my pregnancy care with my GP and the hospital clinic(s). I understand that this involves sharing personal and health information between these two services.

Name: _____ **Signature:** _____ **Date:** _____

Antenatal Clinic Consultants	**SGH**	**TSH**
	☐ Dr T. Miller Drs G. Davis, M. Damasco, A.Henry S. Kanitkar & K Kavanagh-Patel	☐ Dr A. Zuschmann Drs J. Breen, D. Conrad, A. Harris & C. Krishnan

NAME: _____
L.M.P _____ **AGE** _____
E.D.C _____
Gravida _____ **Para** _____

PRESENT PREGNANCY

PV Bleeding: **Yes** ☐ **No** ☐

Current Medications: _____

Drugs of addiction: _____

Cigarettes-no/daily: _____

Alcohol–gm/week: _____

Allergies: _____

PREVIOUS OBSTETRIC HISTORY:

FAMILY HISTORY	**Yes**	**No**
Congenital cardiac conditions	☐	☐
Diabetes	☐	☐
Hypertension	☐	☐
Twins	☐	☐
Hepatitis B	☐	☐
Other congenital abnormalities (e.g. cleft palate, spina bidifa)	☐	☐

Specify:

- Interpreter needed? **Yes** ☐ **No** ☐
- Language required: _____

EXAMINATION

BP _____ at _____ weeks gestation
Heart _____
BMI _____
Lungs _____ Thyroid _____
Abdomen _____
Breast examination _____
Other findings _____

MEDICAL HISTORY	Yes	No
Cardiac	☐	☐
Asthma	☐	☐
Hypertension	☐	☐
Diabetes	☐	☐
Hepatitis	☐	☐
Infertility	☐	☐
Tuberculosis	☐	☐
Sexually Transmitted Infections	☐	☐
Transfusions	☐	☐
Mental Illness	☐	☐
Renal	☐	☐
Epilepsy	☐	☐

Other past History: _____

SOCIAL HISTORY _____

Please ensure the following results are available:

(and a copy to be sent to the Antenatal Clinic/Birth Centre)

Blood group & antibody screen	☐
Full blood count	☐
Haemoglobin EPG (as per hosp. guidelines)	☐
Rubella IgG	☐
Varicella IgG	☐
Syphilis (ELISA)	☐
Hepatitis B (surface antigen)	☐
HIV/Hep C (offered with counselling)	☐
Vitamin D	☐
MSU for M/C/S	☐
Chlamydia PCR if <25 or high risk	☐
Early GTT required (as per protocol)	☐
Date of last CST: 5/12/2019	
18 weeks ultrasound booked	☐
Genetic counselling arranged	☐
NT Plus / NIPT	☐
Early GTT required (as per protocol)	☐
Is low dose aspirin required (as per protocol)	☐
Taking folate/iodine supplements	☐