Canterbury Hospital
Endocrine/Maternity Clinic
Referral Form

ANC Phone: 9787 0183
ANC Fax: 9787 0431

Date of referral õ ..õ /õ õ õ /õ õ

Surnameõ õ õ õ õ ..õ õ õ .õ õ ..õ . Given Name: õ õ õ õ õ õ ..õ ..õ
DOBõ õ /õ õ õ /õ õ õ ..
Addressõ õ õ õ õ õ õ õ õ õ õ õ õ õ õ õ õ õ .õ õ õ õ õ õ õ õ ...
õ .õ õ ...õ .P/C õ õ õ õ õ ..
Best contact Phone No:õ .õ õ õ õ ..õ õ Mobileõ õ õ õ õ õ õ õ õ õ ..

Is an interpreter required? ☐ No ☐ Yes, which language: õ õ õ õ õ õ õ õ õ õ õ õ õ õ õ õ .
Is the patient ineligible for Medicare? ☐ No ☐ Yes
Has the patient already attended her booking visit at Canterbury Antenatal Clinic? ☐ No ☐ Yes

Clinical Information: **Gravida ………..…Para…………… EDD….…/….…./….....Height:.............Weight..............**

Reason for referral: *(tick all that apply)*

☐ Type I Diabetes Mellitus **(RPA ONLY – ph 9515 5888)**
☐ Type 2 Diabetes Mellitus
☐ Gestational Diabetes Mellitus (GDM)
☐ Impaired Fasting Glucose /Impaired Glucose Tolerance (IFG/IGT)
☐ Hypothyroidism
☐ Hyperthyroidism
☐ GravesqDisease
☐ Thyroid nodule
☐ Other endocrine disorderõ õ õ õ õ õ .õ

Investigations: Date of results õ õ ../õ õ õ /õ õ
Results sent with referral: ☐ Yes ☐ No, specify reasonsõ õ õ õ õ õ õ ..

NB: **75gms GTT** results must include:

- 0hr (fasting)
- 1 hr
- 2 hrs
- +/- HbA1C (this will be attended at the GDM Group Education session)

NB: Ensure **Thyroid Function Test results are current i.e < 3 weeks** and must include **:**

- TSH
- fT4
- fT3
- TPOAb
- TgAb
- TSH receptor Ab
- 25-OH-D3

Current medications: ☐ No ☐ Yes *(please list)* õ õ .õ õ õ õ õ õ õ õ õ õ õ õ õ õ õ õ õ
Other investigations performed : ☐ Ultrasound ☐ Other õ õ õ õ õ õ õ õ õ õ õ õ õ õ õ õ ....õ

Any other relevant clinical information (eg. medical or pregnancy history)
õ õ
õ õ

Referrer Details:
Referring Doctor *(please print)*õ õ õ õ õ õ õ õ õ õ õ õ õ õ õ õ õ õ õ ...
Signatureõ .
Phone: õ õ õ õ õ õ õ ....
Provider Numberõ õ õ õ õ õ õ õ õ õ .

GP Stamp & details

Canterbury Hospital Referrals:
Please fax completed referral form and any relevant investigation reports to: (FAX) 9787 0431

Office use only

Date received õ .õ ./õ õ ../õ õ õ Triaged by: õ õ õ õ õ õ õ õ õ õ õ õ õ õ õ õ õ õ õ .
Clinic appointment booked : ☐ GDM Gp Education Date........./......../......... Time: 08.30 am (unbooked) or 8:50am (booked)
☐ GDM Clinic Date........./......../......... Time band: 09.00 . 11.30am **or** 1pm . 3pm
☐ Thyroid Clinic Date........./......../......... Time: õ õ õ õ õ õ Interpreter booked: ☐ Yes......................... ☐ N/A
☐ Midwifwery Booking Appt Date........./......../......... Time: õ õ õ õ õ Data entered on ☐ eMR
Patient notified by: ☐ Phone ☐ Mail Notified and processed by: õ õ õ õ õ õ õ õ õ õ õ õ õ õ õ õ õ
Commentsõ õ