Health
South Eastern Sydney
Local Health District

St George Clinical Genetic Service
Dr Rani Sachdev, Dr Jason Pinner & Mr Dominic Ross
Level 1, Prichard Wing, St George Hospital
Telephone: 9113 3635 Fax: 9113 3694

DATE: **PRENATAL REFERRAL FORM**

Patient Details	**Partner Details**
Surname:	**Surname:**
Given Names:	**Given Names:**
MRN: **DOB:**	**MRN:** **DOB:**
Phone Number:	**Phone Number:**
Address:	**Address:**

Medicare No: ☐☐☐☐☐☐☐☐☐☐ ☐

Interpreter required? Yes/No **Language:**

Relevant History

Parity: G P T M

LMP: **EDC:**

Current Gestation:

Date of Ultrasound:

Gestation at ultrasound:

Blood Group: (please provide written confirmation)

Hospital of Delivery:

Allergies:

Medications:

Reason for Referral

☐ Increased risk of fetal chromosome abnormality
(please include all relevant test results)

☐ Abnormal Ultrasound (please send through ultrasound report)

☐ Thalassemia **(must include partners name & DOB, all screening results, ie. FBC, HbEPG and iron studies)**

☐ Family History

☐ Other

Relevant detail:

Print Name:
Provider No:
Address:

Phone: **Fax:**
Completed By:
(print name)
Signature:
Copy of Report to:

Notes (internal use only)

Women's & Children's Clinics & Clinical Genetics - Prichard Wing Level 1