Canterbury Maternity Health & Pregnancy History Form

Affix Patient ID Label Here

(Hospital Use only)

CANTERBURY HOSPITAL MATERNITY SERVICES

- **This document has TWO sides.**
- **It would be appreciated if you could complete both sides of the form.**
- **Please give completed form, referral letter and copies of any results to the woman to bring to her appointment with the antenatal clinic.**

Options of Referral

☐ **Antenatal Clinic** ☐ **Midwifery Group Practice** ☐ **Midwives Clinic** ☐ **GP Shared Care**

Woman to complete this section

Surname:		Given Names:	
Previous/ Maiden Name:		Occupation:	
Date of Birth:		Medicare No:	Exp Date:
Marital Status:		Country of Birth:	
Language used at home:		Interpreter needed: ☐ Yes ☐ No	
Home Address		Person to Contact	
Street:		Name:	
		Relationship:	
Suburb:		Street:	
State:	P/Code:	Suburb:	
Phone no : (h)		State:	P/Code:
(mob)	(wk)	Phone No:	

USEFUL PHONE NUMBERS

Canterbury Hospital

Main Switch 9787 0000

Antenatal Clinic 9787 0560

Appointments Mon- Fri 8am – 4.30pm

Birthing Unit 9787 0555

Royal Prince Alfred Hospital

Main Switch 9515 6111

Canterbury Hospital

Clinic operating hours - 08:30am to 4:00pm
Monday to Friday excluding Public Holidays
Tel : (02) 9787 0250 or (02) 9787 0560
Fax: (02) 9787 0431.

THIS IS A DOUBLE SIDED FORM

PLEASE COMPLETE THE MEDICAL EXAMINATION AND INVESTIGATION ON REVERSE OF THIS PAGE.

If you consider this referral to be Urgent please call the Antenatal Clinic
(PH: 9787 0250 or 9787 02560 and ask for the Clinic Midwife)

Canterbury Hospital
Antenatal Clinic Level 2
Tudor Street
Campsie NSW 2194

Updated 25 May 2015

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ANTENATAL EXAMINATION & INVESTIGATIONS

LMP:_____ **EDD:**_____ **GRAVIDA:**_____ **PARITY:**_____

Investigations (tick if attended)

		Attended
1	Blood Group & Antibody screen	
2	Haemoglobin	
3	VDRL	
4	Rubella IgG	
5	Hep B surface antigen	
6	Hep C (anti HCV), after discussion	
7	HIV after discussion	
8	Thalassaemia (HbEPG)	
9	Varicella IgG	
10	Glucose Challenge Test	
11	Glucose Tolerance Test	
12	MSU	
13	Ultrasound 18-20 wks FAS	
14	PAP smear	
15	Low Vaginal swab (as required)	
16	Other	

Cardiovascular system	**BP ___/___ at ____ weeks gestation**
Respiratory system	
Abdominal examination	
Thyroid	
Breast Examination	
Pre/early pregnancy weight	
Problems in current pregnancy	
Other Findings	

GP stamp / details: _____
_____
_____
_____
Phone No: _____
Fax No: _____
Provider No: _____
GP Signature_____Date_____

Genetic Counselling

	Yes	No
Genetic Counselling provided	☐	☐
Combined First Trimester Screening	☐	☐
CVS	☐	☐
Amniocentesis	☐	☐
Screening not indicated	☐	☐

Declined-reason_____

Women identified with:

- Personal or family history of genetic conditions (e.g. mental retardation, consanguinity, cystic fibrosis)
- Chromosomal disorders (e.g. trisomy, translocations)
- Congenital abnormalities or physical malformations
- Personal or family history of genetic haematology conditions (e.g. thalassaemia, sickle cell disease, haemophilia)

Referred for Genetic Counselling (Enquiries ph9515 5080)

Referral Form completed ☐ ☐

Note: contact details, gestation, language, reason for referral.

Declined ☐ ☐

Reason: _____

Allergies _____

Current Medications_____

_____

Medical History	Yes	No
Cardiac	☐	☐
Asthma	☐	☐
Hypertension	☐	☐
Endocrine	☐	☐
Mental Illness	☐	☐
Renal	☐	☐
Epilepsy	☐	☐
GIT	☐	☐
Smoker	☐	☐
STIs	☐	☐
Other		

Family History	**Yes**	No
Diabetes	☐	☐
Hypertension	☐	☐
Congenital Abnormalities	☐	☐
Twins	☐	☐
Other		

Please note: It may require more than one visit to the GP's surgery to complete this form.

Please return this form to the woman.

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