Health
NSW GOVERNMENT
Sydney
Local Health District

OBSTETRIC REFERRAL – THE CANTERBURY HOSPITAL

Low Risk Women – Woman to bring completed form to the hospital with relevant screening results

High Risk Women requiring Early or Urgent assessment please fax to 9787 0431

PATIENT DETAILS

DATE / /

Name			
Address			
Phone		**Mobile**	
DOB	/ /	**Email**	
Interpreter? Yes		**No**	**Language**

GP DETAILS

Name			
Address			
Phone		**Fax**	
Provider No			

CLINICAL INFORMATION

LMP __ / __ / ____ EDC __ / __ / ____

OFFICE USE ONLY

Consultants

Dr Aye (Su) Htun 2690125A	**Dr Pui Ru (Kevin) Koh 293106MW**	**Dr Sacha Strockyj 4170082K**

ANTENATAL EXAMINATION & INVESTIGATIONS

LMP:_____ **EDB:**_____ **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	

USEFUL PHONE NUMBERS

Canterbury Hospital

Main Switch - 9787 0000

Antenatal Clinic - 9787 0560 – Clinic operating hours Monday to Friday – 08:30am to 04:30pm (excluding Public Holidays)

Fax – 9787 0431

Birthing Unit - 9787 0555

Dear Doctor,

Early Referral for Genetic testing -

If Genetic testing (with Counselling) is required for this woman (eg. age over 35yrs or family history of genetic disease), please arrange before 12 weeks gestation. If this is not possible please ensure timely referral to the antenatal clinic.

Thank you.

	Yes	No
Genetic Counselling provided	☐	☐
Referred for Genetic Counselling	☐	☐
Genetic Testing or Screening	☐	☐
Nuchal Translucency plus bloods	☐	☐
CVS	☐	☐
Amniocentesis	☐	☐
Declined	☐	☐
Not indicated	☐	☐

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 return this completed form to the woman to bring to her Booking Appointment.