Health
NSW GOVERNMENT | Sydney Local Health District

ANTENATAL THYROID CLINIC REFERRAL FORM

REFERRAL CRITERIA

A. TSH <0.01 (i.e. undetectable TSH) **B. TSH ≥4mIU/L**

C. Current or **past** history of **Graves' disease** **D. Thyroid Nodule**

ALL FIELDS MUST BE COMPLETED OR THE FORM WILL BE RETURNED

Prior to referral please review the Thyroid Disease in Pregnancy Guidelines at https://www.cesphn.org.au/general-practice/help-my-patients-with/child-and-maternal-health/rpa-women-and-babies-canterbury-hospital/resources-for-general-practitioners#tab2 for guidance on further blood tests that may be required prior to our clinic review

To: Dr Ash Gargya
Antenatal Thyroid Clinic, Endocrine Unit
Royal Prince Alfred Hospital (P: 95157225)

Patient Sticker

Dear Dr Gargya,

Re: _____ DOB _____ RPA MRN (if known)_____

Address _____ _____Mob_____

This lady is currently _____ weeks pregnant EDC _____

She presents with

A. ☐ **Hypothyroidism**

☐ new ☐ existing

Date_____ Blood Test <3 wks old

TSH _____

fT4 _____

TPO Ab_____Tg Ab _____

Thyroxine	Dose	Start Date
Current		
Pre pregnancy		

☐ Not commenced

B. ☐ **Hyperthyroidism**

☐ new ☐ existing

Date_____ Blood Test <3 wks old

TSH _____

fT4 _____fT3_____

TSH receptor Ab _____

☐ Anti Thyroid Medication Dose

☐ Propylthiouracil _____

☐ Carbimazole_____

Date Commenced_____

C. ☐ Current or past history of Graves' Disease

D. ☐ Thyroid Nodule

Model of Care

☐ Ante Natal Clinic

☐ Midwives Clinic

☐ Birth Centre

☐ Midwifery Group Practice

Previous thyroid surgery…… ☐ Yes ☐ No describe _____
Previous Radioactive Iodine…….. ☐ Yes ☐ No (date)_____
Currently under Endocrinologist… ☐ Yes ☐ No Dr _____

Can you please assess need for ongoing care in pregnancy and advise,

Dr Stamp

Yours sincerely,
Dr
_____
(please print)

Signature
_____

Date _____

Ph _____

FAX to Ante natal Thyroid Clinic 9515-8728 Patient will be contacted and appointment arranged

Office use only

Triage to
☐ Medical
☐ Nursing

R/V by
☐ Endo Reg 1
☐ Endo Reg 2
☐ _____

Booking Requested Date_____
☐ 1 wk ☐ 2 wks ☐ 4 wks
☐ 6 wks ☐ Not Needed
Actual Date _____Time_____

Blood Test
☐ Attached
☐ N/A

eMR entry ?
Yes_____
No_____

Booking Completed
☐ Booked_____
☐ Posted_____
☐ Collected_____