ANTENATAL REFERRAL FORM

ST GEORGE / SUTHERLAND HOSPITALS AND HEALTH SERVICES
SOUTH EASTERN SYDNEY LOCAL HEALTH DISTRICT

MRN Sticker

Is this patient suitable for GP Shared Care? **[ ]** Yes **[ ]** No (reason:)

Date:

ANC Consultants: **[ ]** STG (Dr T Miller, G Davis, Dr A Henry, Dr S Kanitkar, Dr K Kavanagh-Patel, Dr E Chesterman, Dr E Karantanis, Dr S Thou)

[ ] TSH (Dr A Zuschmann, Dr J Breen, Dr D Conrad, Dr A Harris, Dr C Krishnan, Dr K Roper, Dr N Chan, Dr C Krishnan)

GP Details*

Shared Care provider? **[ ]** Yes **[ ]** No
Practice Name:
Address:
Phone:

Referring GP Name:
Provider Number:

Signed by GP:

Patient Details:

Full name:
DOB:
Contact number: (h)
(m)
Email address:
Home address:

[ ] I agree to my personal and health information being shared between my GP and the hospital clinic(s) for the provision of my healthcare.

Signed by patient:

** If the collaborating GP is a Registrar, please detail the name and provider number of the supervising GP:*

Current Pregnancy:

LMP: ___ EDC: **[ ]** By menstrual calculation **[ ]** By early dating scan **[ ]** Determined by IVF
Maternal age: __ Gravida: Para: ___ Complications so far: **[ ]** No **[ ]** Yes: _
Screening/imaging results so far: __

Current prescription medications:

Multivitamin/CAM/over-the-counter treatments:

Allergies:

Smoking: Alcohol: Other rec. substance use: **[ ]** No **[ ]** Yes

Obstetric/Gynaecological History:

[ ] History of birth-related trauma

Other Personal Medical History:

Date of last CST on record: __ / __/ __
Result:

Relevant Social History:

Family History:

Details if yes ↓

Genetic conditions **[ ]** No **[ ]** Yes
Diabetes/GDM **[ ]** No **[ ]** Yes

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Social History:
Interpreter needed? **[ ]** No **[ ]** Yes:

Htn/pre-eclampsia **[ ]** No **[ ]** Yes
Other congenital **[ ]** No **[ ]** Yes
(e.g. spina bifida, cleft palate, cardiac)
Others not listed: __
None of the above **[ ]**

Examination at __ weeks' gestation: ___

Physical assessment has included:
[ ] Heart **[ ]** Lungs **[ ]** Thyroid **[ ]** Abdomen **[ ]** Breasts
Relevant physical findings:

[ ] Please tick this box if there are special circumstances for which a verbal handover between the GP and the hospital clinic early in this pregnancy would be beneficial and important. GP's preferred contact details:

Has **first trimester screening** been arranged? **[ ]** No **[ ]** Yes, NIPT **[ ]** Yes, Combined 1st Trim Screening/NT Plus

Is this patient on an appropriate **prenatal supplement**? **[ ]** No **[ ]** Yes
Is an **early Glucose Tolerance Test** indicated? **[ ]** No **[ ]** Yes
Is **low dose aspirin** indicated? **[ ]** No **[ ]** Yes
Is **additional folate supplementation** indicated? **[ ]** No **[ ]** Yes
Has a **DV screen** been performed? **[ ]** No **[ ]** Yes
Does this patient have an **active MyHealthRecord**? **[ ]** No **[ ]** Yes **[ ]** Unsure

The following tests have been ordered:

Routine:
[ ] FBC
[ ] Blood group
[ ] Red cell antibody screen
[ ] Rubella IgG
[ ] Varicella IgG
[ ] Syphilis serology
[ ] Hepatitis B surface antigen
[ ] HIV serology
[ ] Hepatitis C serology
[ ] Vitamin D
[ ] Ferritin
[ ] Mid-stream urine MCS
[ ] All the above test completed

As needed:
[ ] HbEPG (as per hospital guidelines)
[ ] Urine chlamydia PCR (if <25 or high risk)
[ ] TSH (if risk factors present)
[ ] Vitamin B12 (if vegan or other risk factor)
[ ] Cervical Screening Test (if due)
[ ] Other:

Pathology company:

[ ] Results copied to Antenatal Clinic

- **INFORMATION FOR PATIENTS** -

Please **bring this completed referral form with you** when you attend your first antenatal appointment at the hospital. Have you completed the **online booking form** yet? If not, please follow the relevant link below. You'll receive an **appointment confirmation letter by email**. There may be a period of wait between submitting your form online and receiving a reply email.

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MRN Sticker

The Sutherland Hospital

St George Hospital