ISLHD- Wollongong MATERNITY SERVICES
REFERRAL FOR ANTENATAL CARE

Booking into Hospital: Phone: 42534284

(Antenatal Clinic- Ph: 42534256 or Fax: 42534258)

Dear Antenatal Clinic Doctor (***please tick***): □ Dr W.Davis □ S. Dikshit □ Dr H. Ananthram □ Dr B. Murali □ Dr E. Tetstall

This referral is:	❑ **URGENT**	❑ **NON-URGENT**	
Preferred model of care:	❑ **GP Shared Care**	❑ **Midwife Care**	❑ **MGP interest (separate request sent)** ❑ **Hospital Care**

Name:		D.O.B:	
Address:			
Telephone:	(H)	(M)	(W)
Does patient require an interpreter:	❑ Yes	❑ No	Language spoken:
Indigenous Status : Aboriginal / Torres Strait Islander / Neither		***Partner***: Aboriginal / Torres Strait Islander / Neither	

No. of pregnancies:	**No. live births:**	**LMP:**	**EDC:**

❑ **Significant Past Medical History** e.g. infection, endocrine, hypertension, renal, cardiac, substance use, mental health

Diagnoses / Comments:

❑ **Significant Past Obstetric History** e.g. recurrent miscarriage, IUGR, PPH, pre-eclampsia, IUFD

Diagnoses / Comments:

❑ **Issue this Pregnancy** (please tick below)

❑ Twins/Multiple (specify e.g. DA/DC etc)	❑ Increased Risk NT	❑ Hypertension	❑ Smoker > 10 / Day
❑Rh / Blood Group Antibodies	❑ Gest Diabetes	❑IVF Pregnancy	❑ Fetal Anomaly
❑ Declined Blood Products	❑ Recurrent Bleeding	❑ Low Lying Placenta	❑ Substance Abuse
❑ Maternal Age <14 or ≥ 40	❑ BMI _____	❑Other (eg low PAPP-A):	

Diagnoses / Comments:

❑ **Significant Family History** e.g. congenital genetic/cardiac, clotting disorders, other

Diagnoses / Comments:

❑ **EDS score >10**

❑ **DV screen attended** -*please circle* -> **DV identified / DV NOT identified**

❑ **Abnormal Test Results –** Please attach copies of all relevant results

Please specify:

_____

Referring Doctors Signature
Date: / /

Referring Doctors Stamp incl. Provider No

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