Health
South Eastern Sydney
Local Health District

Facility: The Royal Hospital for Women

ANTENATAL REFERRAL

FAMILY NAME | MRN
GIVEN NAME | ☐ MALE ☐ FEMALE
D.O.B. ___/___/___ | M.O.
ADDRESS
LOCATION / WARD
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

GP STAMP:

Fax No:
Ph. No:
Provider No:

THIS WOMAN IS TO RETURN TO ME FOR SHARED CARE?
Yes ☐ No ☐

GP Signature: _____
Date: ___/___/_____

When offering Nuchal Translucency Plus testing-please counsel and organise before 12 weeks gestation or ensure early referral to the Antenatal Clinic.

I wish to share my pregnancy care with my GP and the hospital clinic(s). I understand that this involves sharing personal and health information between these two services.

Name _____ **Signature** _____ **Date:** ___/___/_____

Antenatal Clinic Consultants: Dr Coogan, Dr Hawke, Dr Horrowitz, Dr Leader, Dr Lette, Prof. Welsh, Dr Clements, Prof. Bisits, Dr Bowyer, Dr Shand .

NAME _____

L.M.P _____ **Age** _____

E.D.C _____

Gravida _____ **Para** _____

PRESENT PREGNANCY:

	Yes	No
Nausea / vomiting	☐	☐
PV bleeding	☐	☐
Abdominal pain	☐	☐

Current Medications _____

Drugs of Addiction _____

Cigarettes - no / daily _____

Alcohol - gm / week _____

Allergies _____

PREVIOUS OBSTETRIC HISTORY:

FAMILY HISTORY:

	Yes	No
Cardiac	☐	☐
Diabetes	☐	☐
Hypertension	☐	☐
Twins	☐	☐
Hepatitis B	☐	☐
Other congenital abnormalities	☐	☐

Specify _____

- Interpreter needed? Yes ☐ No ☐
- Language required: _____

EXAMINATION:

BP___/___ at ___ weeks gestation

Abdomen _____ Heart _____

Lungs _____ Thyroid _____

Breast examination _____

BMI _____

Other findings:

MEDICAL HISTORY:

	Yes	No
Cardiac	☐	☐
Asthma	☐	☐
Hypertension	☐	☐
Diabetes	☐	☐
Hepatitis	☐	☐
Infertility	☐	☐
Tuberculosis	☐	☐
Sexually Transmitted Infections	☐	☐
Transfusions	☐	☐
Mental Illness	☐	☐
Depression/ Anxiety	☐	☐
Renal	☐	☐
Epilepsy	☐	☐

Other past History _____

SOCIAL HISTORY: _____

Please ensure the following results are available:
(and a copy given to your patient)

Blood group & antibody screen	☐
Full blood count	☐
Haemoglobin EPG (as per hospital guidelines)	☐
Rubella IgG	☐
Varicella IgG	☐
Syphilis (ELISA)	☐
Hepatitis B (surface antigen)	☐
MSU for M/C/S	☐
Pap Smear	☐
HIV	☐
Hep C	☐

Pathology Laboratory _____

18 weeks ultrasound booked: Yes ☐ No ☐

Genetic counselling arranged Yes ☐ No ☐

NT Plus/CVS/Amnio arranged Yes ☐ Declined ☐
(please circle)

Not discussed ☐ Please specify _____

SES060409
Holes punched as per AS2828-2012
BINDING MARGIN - NO WRITING
S0741 120614
ANTENATAL REFERRAL
SES060.409
NO WRITING
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Health
South Eastern Sydney
Local Health District

Facility: The Royal Hospital for Women

ANTENATAL REFERRAL

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____/_____/_____	M.O.
ADDRESS	
LOCATION / WARD	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

Information about your health and wellbeing will be collected and be available to both the hospital and your GP unless otherwise requested.

Woman to complete this section

Surname:		Given Names:
Previous/Maiden Name:		Previous/Maiden Name:
Date of Birth:	Medicare card #:	Exp date:
Marital status: ☐ **Widow** ☐ **Never married** ☐ **Married/De facto** ☐ **Separated** ☐ **Divorced**		
Country of Birth:		Religion:
Language used at home:		Interpreter needed: **Yes** ☐ **No** ☐
Aboriginality: **Yes** ☐ **No** ☐		Torres Strait Islander: **Yes** ☐ **No** ☐
Private insurance: **Top** ☐ **Basic** ☐ **Nil** ☐ **Fund Name:**		**Fund No:**
Billing Status: **Overseas (no Medicare)** ☐ **Reciprocal** ☐ **Medicare** ☐		

Home Address		**Person to Contact**	
Street:		Name:	
		Relationship:	
Suburb:		Street:	
State:	P/code:	Suburb:	
Phone no: (h)		State:	P/code:
(w)	(Mob)	Phone no:	
Have you attended this Hospital before?		Yes ☐ No ☐ If yes, under what surname?	

Would you like Shared Pregnancy Care with your GP & the hospital? *(Shared Care involves alternating visits with your GP and the Hospital clinics)*	Yes ☐	No ☐
Have you previously received pregnancy care at the Royal Hospital for Women?	**Yes** ☐	**No** ☐
Would you like shared Pregnancy Care with your GP & the hospital? *(Shared Care involves alternating visits with your GP and the hospital clinics)*	**Yes** ☐	**No** ☐
Would you like Midwifery Group Practice? (a waiting list usually applies)	**Yes** ☐	**No** ☐
What is your preferred appointment time for your hospital pregnancy care?	**am** ☐	**pm** ☐

☎ USEFUL PHONE NUMBERS

Hospital	9382 6111
Delivery Suite	9382 6100
Appointments	9382 6048
Enquiries 8.30-4.00	Monday-Thursday
Antenatal Classes	9382 6541

PLEASE BRING THIS COMPLETED FORM TO YOUR FIRST ANTENATAL/ BOOKING IN APPOINTMENT AT THE ROYAL HOSPITAL FOR WOMEN

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SES060409

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NO WRITING

SOUTH EASTERN SYDNEY
ILLAWARRA
NSW HEALTH

Facility:

REFERRAL - MATERNITY ASSESSMENT UNIT

FAMILY NAME | MRN

GIVEN NAME | ☐ MALE ☐ FEMALE

D.O.B. _____/_____/_____ | M.O.

ADDRESS

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

SEI010.457

Date: _____

Interpreter Required Y/N _____

Phone Number: _____

Medicare No. : _ _ _ _ _ _ _ _ _ _ / _ Medicare expiry date: ___ / ___ / _____

☐ Private ☐ Hospital ☐ Medicare Ineligible

G: _____ P: _____ Gestation: _____

EDC: _____ LMP: _____

Indication for referral: _____

Relevant History: _____

INVESTIGATIONS REQUIRED

☐ CTG

☐ BP monitoring

☐ Temperature/Pulse

☐ Blood test (specify):

Frequency: _____

☐ Urinalysis

☐ Ultrasound ☐ Growth ☐ AFI & Doppler

Frequency: _____

☐ LVS ☐ Celestone

☐ Anti D

Fluids/medications: _____

Other: _____

Plan / Following review notify: _____

F/U: _____

REFERRING DOCTOR'S SIGNATURE: _____ **DATE:** _____

Requesting Dr	
Provider No.	
Telephone	
Address	

S0485 030712

BINDING MARGIN - NO WRITING

Holes punched as per AS2828-1999

REFERRAL - MATERNITY ASSESSMENT UNIT SEI010.457

NO WRITING

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Health
South Eastern Sydney
Local Health District

Facility: Royal Hospital for Women

PHYSIOTHERAPY DEPARTMENT OUTPATIENT REFERRAL

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____/_____/_____	M.O.
ADDRESS	
LOCATION / WARD	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

SES010421

Holes Punched as per AS2828.1: 2012

BINDING MARGIN - NO WRITING

Royal Hospital for Women: Physiotherapy Department
Phone: 02 9382 6540 Fax: 02 9382 6561

Date: ____/___/_____

The above patient was reviewed today by:

☐ Midwife ☐ RHW Clinic ☐ GP
☐ Private Doctor ☐ Allied Health ☐ Other_____

The patient is currently:

☐ Pregnant _____ weeks
☐ Post-natal _____ weeks
(Please note: musculoskeletal referrals are accepted up to 12 weeks post-natally only)
☐ Gynaecology patient
☐ Oncology patient
☐ Other: _____

Reason for referral:

☐ pelvic floor assessment
☐ musculoskeletal assessment

_____
_____
_____
_____

Please inform the patient there is a waiting list and they will be contacted when there is an appointment available.

Print full name: _____ Signature: _____

Phone: _____

Address for correspondence: _____
_____

Physiotherapy Department

Phone call 1: Date: ____/___/_____ Action: _____
Phone call 2: Date: ____/___/_____ Action: _____
Phone call 3: Date: ____/___/_____ Action: _____
Letter sent: Date: ____/___/_____

Appointment booked: Date:____/___/_____ Time:_____ Physiotherapist:_____

S0868 040516

PHYSIOTHERAPY DEPARTMENT OUTPATIENT REFERRAL

SES010.421

NO WRITING

Level 0,
Royal Hospital for Woman
Barker Street
Randwick NSW 2031
Ph: (02) 9382 6098
Fax: (02) 9382 6038

Maternal Fetal Medicine

At the Royal Hospital for Women
(The New South Wales Fetal Therapy Centre)

Comprehensive Perinatal Care

Dr Lucy Bowyer
MD FRCOG FRANZCOG DDU CMFM

Dr Daniel Challis
FRANZCOG DDU CMFM

Dr Antonia Shand
FRANZCOG DDU CMFM

Prof Alec Welsh
MSo PhD FRCOG FRANZCOG DDU CMFM

Woman Details

DOB: _____ MRN:_____

Surname:_____ First Name:_____

Phone:_____ Mobile:_____

Address:_____

_____

Suburb:_____ State: _____

Postcode:_____

Referred By: _____

Contact Number: _____

Address: _____

_____

Provider Number:_____

Date of Referral: _____

Signature of Referring Dr: _____

LMP: _____ EDB: _____

Relevant Clinical History/Indication for Referral: _____

_____

_____

Prenatal Screening and Diagnosis

Genetic Counselling
First Trimester Screening (NT and Serum)
CVS
Amniocentesis
Other

Tertiary Referral MFM Services

Maternal Fetal Medicine Assessment and Consultation
Ongoing Care and Management of High-Risk Pregnancy
Co-ordination of Care with Sydney Children's Hospital
Other

Finding us

The Royal Hospital for Women, Randwick is co-located with Sydney Children's Hospital and Prince of Wales Hospital Public pay parking is available directly under the hospital and is easily accessed via Barker Street entrance.
The car park lifts bring you to Level 0. Follow the signs to the Royal Hospital for Women and the Department of Maternal Fetal Medicine

About Us

The Department of Maternal Fetal Medicine at the Royal Hospital for Women sees women from the public and private sectors, for a broad range of services. All clients are Medicare billed, including invasive procedures, ultrasound and consultation. We coordinate a broad multidisciplinary team of clinicians for antenatal and perinatal consultation including: midwives; obstetricians; neonatologists; neonatal surgeons; social work

For Appointments or further information Ph: (02) 9382 6089

For Urgent Medical Referrals, please call Ph: (02) 9382 6111 and ask for the Maternal Fetal Medicine Fellow or Consultant to be paged.

Other Useful Contacts

- Genetic Counsellor Ph: (02) 9382 6111 Page 44098
- Clinical Midwife Consultant High Risk Pregnancy Ph: (02) 9382 6111 Page 44919
- Clinical Midwife Specialist Maternal Fetal Medicine Ph: (02) 9382 6111 Page 43983
- Royal Hospital for Women Foundation (Research & Clinical Fundraising) Ph: (02) 9382 6720

Early Pregnancy Assessment Service (EPAS)

Woman Referral
Fax to (02) 9382 6638

Number of Pages including this Coversheet (…….) Date ____/____/____

Attention: Prof W Ledger

Woman Details

Surname _____ First Name_____

Address _____

_____ Postcode_____

D.O.B _____/_____/_____ Medicare Number_____

Phone _____ Mob _____

G ____P____ LMP ____/____/_____ Weeks Gestation ___/40

Symptoms

_____

_____

_____

Blood Group_____ Date Taken ___/___/___

Antibody screen _____ Date Taken ___/___/___

Anti-D given Y / N Dose _____IU Date ___/___/___

FBC _____ Date Taken ___/___/___

ß hCG _____ Date Taken ___/___/___

Ultrasound Date Performed ___/___/___ □ Please attach report

Referring Doctor Details: Date of referral ___/___/___

Doctor _____ Provider No _____

Address _____

Phone _____ Fax: _____

Email _____

Thank you for completing the above details.