MRN:

REFERRAL & ANTENATAL BOOKING FORM

St George / Sutherland Hospitals and Health Services
South Eastern Sydney Local Health District

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

Patient to complete this section

Surname:		Given Names:	
Previous/Maiden Name:		Occupation:	
Marital status: ☐ Widow ☐ Never married ☐ Married/De facto ☐ Separated ☐ Divorced			
Date of Birth:	Country of birth:	Religion:	
Language used at home:		Interpreter needed: **Yes** ☐ **No** ☐	
Will baby be Aboriginal: **Yes** ☐ **No** ☐		Will baby be Torres Strait Islander: **Yes** ☐ **No** ☐	
Pre-pregnancy Weight: _____ Kg		Height: _____ cm	
Home Address		**Next of Kin**	
Street:		Name:	
		Relationship:	
Suburb:		Street:	
State:	P/code:	Suburb:	
Phone no: (h)		State:	P/code:
(w) (Mob)		Phone no:	
Medicare Eligibility: **Overseas (no Medicare)** ☐ **Reciprocal** ☐ **Medicare** ☐			
Medicare card no:		Expiry date:	
Health fund: **Yes** ☐ **No** ☐	Fund name:	Policy no:	
Insured for pregnancy related services: **Yes** ☐ **No** ☐ **Not Sure** ☐			
Are you aware of the obstetric private billing arrangement: **Yes** ☐ **No** ☐			

Have you attended St George Hospital before as a patient?	**Yes** ☐ **No** ☐
Have you attended Sutherland Hospital before as a patient?	**Yes** ☐ **No** ☐
If Yes, under what surname?	
Have you previously received pregnancy care at St George **(☐)** or Sutherland **(☐)** Hospitals? If so, which clinic did you attend? _____	
Would you like the same care for this pregnancy?	**Yes** ☐ **No** ☐
(*The options below are for low risk pregnancy*)	
Are you interested in the St George Birth Centre for your pregnancy care?	**Yes** ☐ **No** ☐
Are you interested in the St George Home Birth program with a midwife for pregnancy care?	**Yes** ☐ **No** ☐

☎ USEFUL PHONE NUMBERS

Centralised Antenatal Appointment Booking Inquiries

(02) 9113 2162

St George Hospital Main Switchboard	9113 1111
Sutherland Hospital Main Switchboard	9540 7111
Interpreter Service	131 450

Please **bring** this completed form with you when you attend your **first** antenatal appointment.

The location of your appointment will be advised on your appointment confirmation letter.

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GP Name: _____
Practice Name: _____
Practice Address: _____
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	**SGH** ☐ Drs T. Miller, S. Thou, G. Davis, A. Henry & S. Kanitkar	**TSH** ☐ Drs A. Zuschmann & J. Breen

NAME _____

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

E.D.C _____

Gravida _____ **Para** _____

PRESENT PREGNANCY:	**Yes**	**No**
PV bleeding / Complications	☐	☐

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**

Heart _____

BMI _____

Lungs _____ Thyroid _____

Abdomen _____

Breast examination _____

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 to be sent to the Antenatal Clinic/Birth Centre)

Blood group & antibody screen	☐
Full blood count	☐
Haemoglobin EPC (as per hospital guidelines)	☐
Rubella IgG	☐
Varicella IgG	☐
Syphilis (ELISA)	☐
Hepatitis B (surface antigen)	☐
HIV/Hep C (offered with counselling)	☐
Vitamin D	☐
MSU FOR M/C/S (plus Chlamydia PCR if <25 or high risk)	☐
Pap Smear	☐

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* _____

_____