**Is this patient suitable for GP Shared Care?** 🞎 Yes 🞎 No (reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) Date: \_\_\_ / \_\_\_ /\_\_\_\_\_\_\_

**ANC Consultants:**

🞎 STG (Dr T Miller, Dr G Davis, Prof A Henry, Dr S Kanitkar, Dr K Kavanagh-Patel, Dr C Duong)

🞎 TSH (Dr A Zuschmann, Dr D Conrad, Dr A Harris, Dr N Peters, Dr K King, Dr C Krishnan, Dr D Krishnan)

**GP Details\*:** **Patient Details:**

Shared Care provider? 🞎 Yes 🞎 No Full name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 DOB: \_\_\_ / \_\_\_ / \_\_\_\_\_\_ Contact number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*[Stamp]*

 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 GP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 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: \_\_\_\_\_\_ G\*P\*M\*T\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Complications so far: 🞎 No 🞎 Yes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Screening/imaging results so far: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current prescription medications: Multivitamin/CAM/over-the-counter treatments:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies: 🞎 No known allergies 🞎 Yes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Smoking/Vaping: 🞎 No 🞎 Yes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alcohol: 🞎 No 🞎 Yes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other rec. substance use: 🞎 No 🞎 Yes

**Obstetric/Gynaecological History: Other Personal Medical History:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞎 History of birth-related trauma \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of last CST on record:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_\_\_

Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Family History: Details if yes🡫**

Genetic conditions 🞎 No 🞎 Yes

Diabetes/GDM 🞎 No 🞎 Yes

**Relevant Social History:** Htn/pre-eclampsia 🞎 No 🞎 Yes

Interpreter needed? 🞎 No 🞎 Yes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other congenital (e.g. 🞎 No 🞎 Yes

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ spina bifida, cleft palate, cardiac)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other not listed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Examination at \_\_\_\_\_\_\_ weeks’ gestation:**

Blood pressure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ BMI: \_\_\_\_\_\_\_\_ Relevant physical findings:

Height: \_\_\_\_\_\_\_ cms Weight: \_\_\_\_\_\_\_ kgs \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physical assessment has included: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞎 Heart 🞎 Lungs 🞎 Thyroid 🞎 Abdomen 🞎 Breasts \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞎 **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, Hep B Surface Antigen, HIV Serology, Hep C Serology, Vitamin D, Ferritin, Mid-Stream Urine MCS

**Pathology company:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**🞎 Results copied to Antenatal Clinic**

*As needed:*

🞎 HbEPG (as per CESPHN protocol)

🞎 Urine Chlamydia PCR (e.g. ≤25 years old or high risk)

🞎 TSH (e.g. risk factors present)

🞎 Vitamin B12 (e.g. vegan or other risk factor)

🞎 Cervical Screening Test (if due)

🞎 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **• 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.

 

 **The Sutherland Hospital** **St George Hospital**

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