

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, 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*:

Shared Care provider? Yes No

[Stamp]

Patient Details:

Full name: _____
DOB: ___/___/_____ Contact number: _____
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:

History of birth-related trauma

Other Personal Medical History:

Date of last CST on record: ___/___/_____

Result: _____

Relevant Social History:

Interpreter needed? No Yes: _____

Family History:

Details if yes↓

Genetic conditions No Yes

Diabetes/GDM No Yes

Htn/pre-eclampsia 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: _____

Height: _____ cms Weight: _____ kgs

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

Pathology company: _____

As needed:

HbEPG (as per CESP HN 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: _____

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.



The Sutherland Hospital



St George Hospital