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]

Signed by GP: _____

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 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

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

Result: _____

Relevant Social History:

Interpreter needed? ☐ No ☑ Yes: _____

_____

_____

Other Personal Medical History:

_____

_____

_____

_____

_____

_____

Family History: **Details if yes↓**

Genetic conditions	☐ No ☐ Yes	
Diabetes/GDM	☐ No ☐ Yes	
Htn/pre-eclampsia	☐ No ☐ Yes	
Other congenital (e.g. spina bifida, cleft palate, cardiac)	☐ No ☐ Yes	

Other not listed: _____

Updated Dec 2024

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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: _____

☐ **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

Updated Dec 2024