Health
NSW GOVERNMENT | Sydney Local Health District

# ANTENATAL THYROID CLINIC REFERRAL FORM

**REFERRAL CRITERIA**

**A. TSH <0.01** (i.e. undetectable TSH) **B. TSH ≥4mIU/L**

**C. Current** or **past** history of **Graves' disease** **D. Thyroid Nodule**

**ALL FIELDS MUST BE COMPLETED OR THE FORM WILL BE RETURNED**

**Prior to referral please review the Thyroid Disease in Pregnancy Guidelines at https://www.cesphn.org.au/general-practice/help-my-patients-with/child-and-maternal-health/rpa-women-and-babies-canterbury-hospital/resources-for-general-practitioners#tab2 for guidance on further blood tests that may be required prior to our clinic review**

To: Dr Albert Hsieh
Antenatal Thyroid Clinic, Endocrine Unit
Royal Prince Alfred Hospital (P: 95157225)

Patient Sticker

Dear Dr Hsieh,

Re: _____ DOB _____ RPA MRN (if known)_____

Address _____ _____Mob_____

This lady is currently _____ weeks pregnant EDC _____

She presents with

**A.** ☐ **Hypothyroidism**

☐ new ☐ existing

Date_____ Blood Test <3 wks old

TSH _____

fT4 _____

TPO Ab_____Tg Ab _____

| Thyroxine | Dose | Start Date |
|---|---|---|
| Current | | |
| Pre pregnancy | | |

☐ Not commenced

**B.** ☐ **Hyperthyroidism**

☐ new ☐ existing

Date_____ Blood Test <3 wks old

TSH _____

fT4 _____fT3_____

TSH receptor Ab _____

☐ Anti Thyroid Medication Dose

☐ Propylthiouracil _____

☐ Carbimazole_____

Date Commenced_____

**C.** ☐ Current or past history of Graves' Disease

**D.** ☐ Thyroid Nodule

**Model of Care**

☐ Antenatal Clinic

☐ Midwives Clinic

☐ Birth Centre

☐ Midwifery Group Practice

Previous thyroid surgery…… ☐ Yes ☐ No describe _____
Previous Radioactive Iodine…….. ☐ Yes ☐ No (date)_____
Currently under Endocrinologist… ☐ Yes ☐ No Dr _____

Can you please assess need for ongoing care in pregnancy and advise,

Dr Stamp

Yours sincerely,
Dr
_____
*( please print )*

Signature _____

Date _____

Ph _____

**FAX to Ante natal Thyroid Clinic 9515-8728 Patient will be contacted and appointment arranged**

Office use only

Triage to ☐ Medical ☐ Nursing

R/V by ☐ Endo Reg 1 ☐ Endo Reg 2 ☐ _____

Booking ☐ 1 wk ☐ 2 wks ☐ 4 wks ☐ 6 wks ☐ Not Needed
Requested Date_____
Actual Date _____Time_____

Blood Test ☐ Attached ☐ N/A

eMR entry ? Yes_____ No_____

Booking Completed ☐ Booked_____ ☐ Posted_____ ☐ Collected_____