SLHD ANTENATAL THYROID CLINIC REFERRAL FORM

Health
NSW GOVERNMENT | Sydney Local Health District

REFERRAL CRITERIA

A. Hypothyroidism (TSH >4) **B. Hyperthyroidism (TSH <0.01)**
C. Current/previous Graves' disease **D. Thyroid Nodule or Cancer**

Please email or fax referral to the RPA Endocrine and Metabolism Unit.

Prior to referral, please review the Thyroid Disease in Pregnancy Guidelines at https://cesphn.org.au/wp-content/uploads/2022/09/Thyroid_ANC_GP_Flowchart_June2018_v2.pdf for guidance on further blood tests that may be required prior to our clinic review

To: Dr Ash Gargya / Dr Albert Hsieh
Antenatal Thyroid Clinic, Endocrine and Metabolism Unit
Royal Prince Alfred Hospital, Camperdown NSW 2050
Ph: (02) 9515 7225 Fax: (02) 9515 8728
E: SLHD-RPAEndocrinology@health.nsw.gov.au

Attach Patient Sticker

Dear Dr Gargya / Dr Hsieh,

Patient name _____ DOB _____ RPA MRN (if known) _____

Address _____ Mob _____

Patient is currently _____ weeks pregnant EDC _____ EDD _____

This patient presents with (TICK REFERRAL CRITERIA) (incomplete forms will be returned)

☐ **A. Hypothyroidism (TSH > 4 mIU/L)**	☐ **B. Hyperthyroidism (TSH < 0.01 mIU/L)**	☐ **C. Graves' disease**
☐ New ☐ Existing	☐ New ☐ Existing	☐ New ☐ Existing
Pathology Lab: _____ Date*: _____ *Blood test must be <3 weeks old TSH _____ fT4 _____ TPO Ab _____	Pathology Lab: _____ Date*: _____ *Blood test must be <3 weeks old TSH _____ fT4 _____ fT3 _____ TSH receptor Ab _____	
On thyroxine ☐ Yes ☐ No Please specify dose + frequency Current: _____ Pre-pregnancy: _____ Date commenced: _____	**On antithyroid medication** ☐ Yes ☐ No ☐ Propylthiouracil Dose + Frequency: _____ ☐ Carbimazole Dose + Frequency: _____ Date commenced: _____	
☐ **D. Thyroid nodule or thyroid cancer history** Neck ultrasound Date _____ Radiology provider _____ TSH _____ (date: _____ lab: _____) Details: _____	**Additional details (if applicable)** ☐ Previous thyroid surgery ☐ Previous radioactive iodine ☐ Currently seeing endocrinologist *(please specify name)* Details: _____	

Referrer details
Name _____ Provider no _____
Practice _____
Phone _____ Fax _____
Signature _____ Date _____

Pregnancy model of care
☐ Antenatal clinic
☐ Midwives Clinic
☐ Birth Centre
☐ Midwifery Group Practice

Office use only

Booking: ☐ Appointment required Requested Date _____ Time _____
☐ No appointment required Reason: _____