



Facility: The Royal Hospital for Women

D.O.B. ____/____/____

M.O.

ADDRESS

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

GP STAMP:

Fax No:

Ph. No:

Provider No:

THIS WOMAN IS TO RETURN
TO ME FOR SHARED CARE?

☐ Yes ☐ No

GP Signature: _____

Date: ____/____/____

When offering first trimester screening for Aneuploidy, please counsel and organise before 13 weeks gestation.

Consultants: Dr Coogan, Dr Fay, Dr Lee, Dr Owen

NAME _____ Age _____

L.M.P _____ Regular / Irregular _____

E.D.C _____

Gravida _____ Para _____ Miscarriage _____

CURRENT PREGNANCY: (tick if present)

☐ Nausea / vomiting

☐ PV bleeding

☐ Abdominal pain

Current Medications _____

☐ Folic Acid ☐ Iodine

Cigarettes - number per day _____

Alcohol - gm / week _____

Allergies _____

PREVIOUS OBSTETRIC HISTORY:

Year of Birth	Gestation	Birth Weight	Pregnancy Issues	Type of Birth	Postnatal Issues

FAMILY HISTORY: (tick if present)

☐ Cardiac

☐ Bleeding issues

☐ Diabetes

☐ Mental Health

☐ Hypertension

☐ Congenital abnormalities Specify _____

EXAMINATION:

BP ____/____ at ____ weeks gestation

Abdomen _____ Heart _____

Lungs _____ Thyroid _____

Breast examination _____

BMI _____

Other findings:

MEDICAL HISTORY: (tick if present)

☐ Hypertension

☐ Hepatitis: Specify _____

☐ Endocrine:

☐ Cardiac

☐ Diabetes

☐ Asthma

☐ Thyroid

☐ Renal

☐ PCOS

☐ Epilepsy

☐ Other: _____

☐ Transfusions

☐ Infertility/IVF

☐ Mental Health:

☐ Endometriosis

Specify _____

☐ Sexually Transmitted Infections

☐ Depression / Anxiety

Other past History _____

Previous surgery (especially uterine) _____

SOCIAL HISTORY: _____

RESULTS

Please ensure the following results are available:
(and a copy given to your patient)

Blood group &
antibody screen

Syphilis (ELISA)

Hepatitis B (surface antigen)

Full blood count

Hepatitis C

Ferritin

HIV

Haemoglobin EPG

MSU for M/C/S

(as per hospital guidelines)

Rubella IgG

Cervical Screening Test

High Risk results

☐ Yes

☐ No

HPV Date _____

LBC Date _____

Result _____

Prenatal Diagnosis arranged

☐ Yes

☐ Declined

If yes, then type arranged

☐ NT Plus

☐ Other

Specify _____

Genetic counselling arranged

☐ Yes

☐ No

Morphology ultrasound booked

☐ Yes

☐ No



SES060409

Holes Punched as per AS2828.1: 2019

BINDING MARGIN - NO WRITING



FAMILY NAME

MRN

GIVEN NAME

☐ MALE ☐ FEMALE

Facility: The Royal Hospital for Women

D.O.B. ____ / ____ / ____

M.O.

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ANTENATAL REFERRAL

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

WOMAN TO COMPLETE THIS SECTION

Family Name:

Given Names:

Previous/Family Name:

Previous/Family Name:

Date of Birth:

Medicare card #: ____ / ____ Exp date:

Marital status: ☐ De Facto ☐ Divorced ☐ Married ☐ Never married ☐ Separated ☐ Widowed
☐ Declined to respond ☐ Unknown

Country of Birth:

Religion:

Language used at home:

Interpreter needed: ☐ Yes ☐ No

Are you Australian Aboriginal? ☐ Yes ☐ No

Are you Torres Strait Islander? ☐ Yes ☐ No

Is the father of the baby Australian Aboriginal? ☐ Yes ☐ No

Is the father of the baby Torres Strait Islander? ☐ Yes ☐ No

Private insurance: ☐ Yes ☐ No Fund Name:

Fund No:

Billing Status: ☐ Overseas (no Medicare) ☐ Reciprocal ☐ Medicare

Home Address

Person to Contact

Street:

Name:

Relationship:

Suburb:

Street:

State:

P/code:

Suburb:

Phone no: (h)

State:

P/code:

(w)

(Mob)

Phone no:

Have you attended this Hospital before?

☐ Yes ☐ No

If yes, under what family name?

Have you previously received pregnancy care at the Royal Hospital for Women

☐ Yes ☐ No

Would you like Shared Pregnancy Care with your GP & the hospital?

☐ Yes ☐ No

(Shared Care involves alternating visits with your GP and the Hospital clinics)

Would you like Midwifery Group Practice? (a waiting list usually applies)

☐ Yes ☐ No

What is your preferred appointment time for your hospital pregnancy care?

☐ am ☐ pm

I agree that my personal health information may be shared between my GP and the hospital.

Name _____ Signature _____ Date: ____ / ____ / ____

**PLEASE BRING THIS COMPLETED FORM TO YOUR FIRST ANTENATAL/BOOKING
IN APPOINTMENT AT THE ROYAL HOSPITAL FOR WOMEN**

Holes Punched as per AS2828.1: 2019
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