

# ANTENATAL REFERRAL FORM to Royal Hospital For Women

Information about your health and wellbeing will be collected and be available to both the hospital and your GP unless otherwise requested.

Patient to complete this section

Surname ..... Given Names .....

Address ..... Postcode .....

Phone (H) ..... (W) ..... (Mob) .....

Marital Status:

Married

De facto

Separated

Single

Divorced

Widow

Country of Birth ..... Religion .....

Date of Birth ...../...../..... Medicare No. \_ \_ \_ \_ \_ Exp date ...../.....

Language used at home ..... Interpreter needed? Yes  No

**Person for notification** ..... Relationship .....

Address ..... Postcode .....

Phone (H) ..... (W) ..... (Mob) .....

Have you attended the Royal Hospital for Women before? Yes  No

If Yes, under what surname? .....

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)*

Have you previously received pregnancy care at the Royal Hospital for Women? Yes  No

If yes, please tick the type of care received Birth Centre  Antenatal Clinic

Would you like the same care for this pregnancy? Yes  No


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

Are you interested in the Birth Centre for your pregnancy care? Yes  No

## USEFUL PHONE NUMBERS

Hospital 9382 6111  
Birth Centre 9382 6116  
Antenatal Clinic 9382 6446  
Bookings/Enquiries 9382 6048  
Enquiries 8.30-4.00 Monday-Thursday

## PLEASE RETURN COMPLETED FORM TO:

 Antenatal Booking Clerk  
**ROYAL HOSPITAL FOR WOMEN**  
**Barker Street**  
**Randwick**  
**NSW 2031**

# ANTENATAL REFERRAL FORM to Royal Hospital For Women

<b>GP STAMP:</b>  Fax No: Ph: No: Provider No:	<b>THIS WOMAN IS TO RETURN TO ME FOR SHARED CARE?</b> Yes <input type="checkbox"/> No <input type="checkbox"/>
	<b>GP Signature:</b> ..... Date: ...../...../.....

Antenatal Clinic Consultants: <b>Dr Lee *</b> <b>Dr Horowitz</b>	<b>Dr Nand *</b> <b>Dr Buist</b>	<b>Dr Hawke *</b> <b>Dr Coogan</b>	<b>Dr Challis</b> <i>* Female</i>
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<b>NAME:</b> ..... <b>L.M.P.:</b> ..... <b>E.D.C.:</b> ..... <b>Gravida:</b> ..... <b>Para:</b> ..... <b>PRESENT PREGNANCY:</b> Yes      No Nausea / vomiting <input type="checkbox"/> <input type="checkbox"/> PV bleeding <input type="checkbox"/> <input type="checkbox"/> Abdominal pain <input type="checkbox"/> <input type="checkbox"/> Current Medications ..... ..... Drugs of Addiction: ..... Cigarettes –no / daily:..... Alcohol – gm / week:..... Allergies:..... <b>PREVIOUS OBSTETRIC HISTORY:</b> ..... ..... ..... <b>FAMILY HISTORY:</b> Yes      No Cardiac <input type="checkbox"/> <input type="checkbox"/> Diabetes <input type="checkbox"/> <input type="checkbox"/> Hypertension <input type="checkbox"/> <input type="checkbox"/> Twins <input type="checkbox"/> <input type="checkbox"/> Hepatitis B <input type="checkbox"/> <input type="checkbox"/> Other congenital abnormalities <input type="checkbox"/> <input type="checkbox"/> Specify ..... Genetic counselling arranged <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> <b>SOCIAL HISTORY:</b> ..... ..... ..... ❖ Interpreter needed? <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/> ❖ Language required: .....	<b>MEDICAL HISTORY:</b> <table style="width: 100%; border: none;"> <tr> <td></td> <td style="text-align: center;">Yes</td> <td style="text-align: center;">No</td> </tr> <tr> <td>Cardiac</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Asthma</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Hypertension</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Diabetes</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Hepatitis</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Infertility</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Tuberculosis</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Sexually Transmitted Infections</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Transfusions</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Mental Illness</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Depression/Anxiety</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Renal</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Epilepsy</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Other past History .....</td> <td></td> <td></td> </tr> <tr> <td>.....</td> <td></td> <td></td> </tr> <tr> <td>.....</td> <td></td> <td></td> </tr> </table> <p><b>Please ensure the following results are available:</b> (and a copy to be sent to the Antenatal Clinic/Birth Centre)</p> <table style="width: 100%; border: none;"> <tr> <td>Blood group &amp; antibody screen</td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Full blood count</td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Rubella IgG</td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Syphilis (Eliza)</td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Hepatitis B (surface antigen)</td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Pap Smear</td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>HIV/Hep C (offered with counselling)</td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Pathology Laboratory .....</td> <td></td> </tr> <tr> <td>18 weeks ultrasound booked: Yes <input type="checkbox"/> No <input type="checkbox"/></td> <td></td> </tr> </table> <p><b>EXAMINATION:</b>                  BP ...../..... at ..... weeks gestation                  Abdomen:..... Heart:.....                  Lungs:..... Thyroid:.....                  Breast examination: .....                  Other findings:.....                  .....                  .....</p>		Yes	No	Cardiac	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Infertility	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Infections	<input type="checkbox"/>	<input type="checkbox"/>	Transfusions	<input type="checkbox"/>	<input type="checkbox"/>	Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	Depression/Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Renal	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Other past History .....			.....			.....			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