

# ANTENATAL REFERRAL FORM to Central Hospital Network - St George or Sutherland Hospital

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

Woman to complete this section

Surname:		Given Names:	
Previous/Maiden Name:		Occupation:	
Date of Birth:		Medicare card no:	
Marital status: <input type="checkbox"/> Widow <input type="checkbox"/> Never married <input type="checkbox"/> Married/De facto <input type="checkbox"/> Separated <input type="checkbox"/> Divorced			
Country of Birth:		Religion:	
Language used at home:		Interpreter needed:    Yes <input type="checkbox"/> No <input type="checkbox"/>	
Aboriginality:    Yes <input type="checkbox"/> No <input type="checkbox"/>		Torres Strait Islander:    Yes <input type="checkbox"/> No <input type="checkbox"/>	
Billing Status:    Overseas (no Medicare) <input type="checkbox"/> Reciprocal <input type="checkbox"/> Medicare <input type="checkbox"/>			Fund Name:
Private insurance:    Top <input type="checkbox"/> Basic <input type="checkbox"/> Nil <input type="checkbox"/>			Fund No:
<b>Home Address</b>		<b>Person to contact</b>	
Street:		Name:	
		Relationship:	
Suburb:		Street:	
State:	P/code:	Suburb:	
Phone no: (h)		State:	P/code:
(w)	(Mob)	Phone no:	

Have you previously attended St George Hospital before?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Have you previously attended Sutherland Hospital before?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If Yes, under what surname?	
Have you previously received pregnancy care at St George ( <input type="checkbox"/> ) or Sutherland ( <input type="checkbox"/> ) Hospitals? If so, which clinic did you attend? .....	
Would you like the same care for this pregnancy?	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>(Below are for low risk, no drugs options of care)</b>	
Are you interested in the St George Birth Centre for your pregnancy care?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Are you interested in the St George Home Birth program with a midwife for pregnancy care?	Yes <input type="checkbox"/> No <input type="checkbox"/>

**USEFUL PHONE NUMBERS**

**Sutherland Hospital**

Main Switchboard                    9540 7111  
 Antenatal Clinic                    9540 7240  
 Appointment Enquiries ~ Mon – Fri 9 am – 4.30 pm  
 Antenatal Assessment Unit    9540 8654  
 Clinical Enquiries ~ Mon to Friday 8.30 am – 4.30 pm  
 Birthing Suite                        9540 7982/7981

**St George Hospital**

Main Switchboard                    9113 1111  
 Birth Centre                         9113 3103  
 Antenatal Clinic                    9113 2162  
 Delivery Suite                        9113 2126  
 St George Bookings/Info    9113 2162 from  
 8.30am – 3.30 pm Mon to Thurs & 8.30am – 12.00 pm Fri

**PLEASE RETURN COMPLETED FORM TO:**

Antenatal Booking Clerk  
 Sutherland Hospital  
 Locked Bag 21, Taren Pt NSW 2229  
 or fax to 9540-7304

**OR**

Antenatal Booking Clerk  
 St George Hospital  
 Gray Street, Kogarah NSW 2217  
 or fax to 9113-3765

to receive your appointment

**ANTENATAL REFERRAL FORM** to Central Hospital Network - St George or Sutherland Hospital

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

I wish to share my pregnancy care with my GP and the hospital clinic(s). I understand that this involves sharing personal and health information between these two services.

Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

**NAME** \_\_\_\_\_

**L.M.P** \_\_\_\_\_ **Age** \_\_\_\_\_

**E.D.C** \_\_\_\_\_

**Gravida** \_\_\_\_\_ **Para** \_\_\_\_\_

**PRESENT PREGNANCY:** Yes No

Nausea / vomiting  Yes  No

PV bleeding  Yes  No

Abdominal pain  Yes  No

Current Medications \_\_\_\_\_

\_\_\_\_\_

Drugs of Addiction \_\_\_\_\_

Cigarettes –no / daily \_\_\_\_\_

Alcohol – gm / week \_\_\_\_\_

Allergies \_\_\_\_\_

**PREVIOUS OBSTETRIC HISTORY:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**FAMILY HISTORY:** Yes No

Cardiac  Yes  No

Diabetes  Yes  No

Hypertension  Yes  No

Twins  Yes  No

Hepatitis B  Yes  No

Other congenital abnormalities  Yes  No

Specify \_\_\_\_\_

Genetic counselling arranged  Yes  No

**SOCIAL HISTORY:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

❖ Interpreter needed? Yes  No

❖ Language required: \_\_\_\_\_

**MEDICAL HISTORY:**

	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 \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Please ensure the following results are available:** (and a copy to be sent to the Antenatal Clinic/Birth Centre)

Blood group & antibody screen

Full blood count

Rubella IgG

Varicella IgG

Syphilis (ELISA)

Hepatitis B (surface antigen)

Pap Smear

HIV/Hep C (offered with counselling)

Pathology Laboratory \_\_\_\_\_

18 weeks ultrasound booked: Yes  No

Genetic tests arranged Yes  Declined

**Not discussed**  Please specify \_\_\_\_\_

**EXAMINATION:**

BP \_\_\_/\_\_\_ at \_\_\_ weeks gestation

Abdomen \_\_\_\_\_ Heart \_\_\_\_\_

Lungs \_\_\_\_\_ Thyroid \_\_\_\_\_

Breast examination \_\_\_\_\_

Other findings \_\_\_\_\_

\_\_\_\_\_