REQUEST FOR PREGNANCY CARE CLINIC APPOINTMENT – FAX 03 4215 1383

Referral to:	**REFERRING GENERAL PRACTITIONER:**
Barwon Health Pregnancy Care (Director of Women's Services, Dr Michael Shembrey) [DEPT: PCC] Fax: 03 4215 1383 **Service requested:** Pregnancy Care Clinic	Name: Practice Name: Address: Telephone: Fax: Email: Barwon Health

PATIENT DETAILS:

Family Name: Previous Name: Given Name:

Address: Suburb: Postcode:

Telephone: Other Telephone contact:

Next of Kin or Contact Person:

DOB: Age: Medicare Number:

Mother Aboriginal or Torres Strait Islander: Yes ☐ No ☐ Baby Aboriginal or Torres Strait Islander: Yes ☐ No ☐

Interpreter required: Yes ☐ No ☐ Language:

REFERRAL DETAILS: **DATE OF REFERRAL:**

Age: Gravida: Parity: LNMP: EDB:

Periconceptual folic acid: Yes ☐ No ☐ First trimester folic acid: Yes ☐ No ☐

KNOWN RISK FACTORS AND COMMENTS:	**GENETIC HX:**
PREVIOUS OBSTETRIC Hx: **(Include number of previous CS):**	**PAST MEDICAL Hx:**
MEDICATIONS:	**Allergies:**
Smoker: Yes ☐ No ☐ Quit ☐ If quit, when?	**Alcohol:**

Substance Use (specify):

Available to attend clinic on (please circle <u>all</u> options patient is available to attend):

Mon AM / Mon PM / Tues AM / Tues PM / Wed AM / Wed PM / Thurs AM / Thurs PM

PATHOLOGY ORDERED: Please cc PCC for all results ordered

FBE ☐ Blood Grp ☐ Antibodies ☐ Hep B ☐ Hep C ☐ HIV ☐ RPR ☐ Rubella ☐ Varicella ☐

MSU ☐ Vit D ☐ Chlamydia ☐ Pathology provider:

SCREENING: Downs syndrome screening discussed? Yes ☐ No ☐

Downs syndrome screening performed (US/Path)? Yes ☐ No ☐ Has CVS/Amnio been arranged? Yes ☐ No ☐

Dating USS ordered? Yes ☐ No ☐	Result:		Date:	
19 week morphology USS ordered? Yes ☐ No ☐	Result:		Date:	
Circle radiology provider: BMI / GMI / Lake Imaging / Geel USS for Women / Other:_____				
Ppap smear in last 24/12? Yes ☐ No ☐	Result:	Prov:	Date:	

SHARED CARE:

I am willing to participate in shared antenatal care if indicated: ☐Yes ☐ No

I have discussed the shared care option with this patient: ☐Yes ☐ No

I am currently credentialled with Barwon Health for AN shared care? ☐Yes ☐ No

Signature of Referring Physician:_____

Date:_____