REQUEST FOR PREGNANCY CARE CLINIC APPOINTMENT – FAX 03 4215 1383

REFERRING GENERAL PRACTITIONER DETAILS:

Name:

Practice Name:

Address:

Telephone:

Fax:

Email:

PATIENT DETAILS:

Family Name: Previous Name: Given Name:

Address: Suburb: Postcode:

Telephone:

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: EDD:

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:

Smoking: **Alcohol**: **Recreational drug use:**

Able to attend clinic on (please choose more than one): Mon AM Tues AM Wed AM Thurs AM

PATHOLOGY ORDERED: Please cc ANC for all results ordered

FBE	☐	Blood Group	☐	Antibodies	☐	Hep B	☐	Hep C	☐
HIV	☐	RPR	☐	Rubella	☐	Varicella	☐	MSU	☐

Ultrasound	Result:	Provider:	Date:
Last Pap Smear Has a Pap Smear been performed in the last 12/12 Yes ☐ No ☐	Result:	Provider:	Date:

SHARED CARE

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

Signature of Referring Physician: .... **Date**:..

Version 6a - Revised & Updated: Nov 2012