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| GP Referralto Bendigo Health for Pregnancy Care**omniana-0312.1-bh** |  | **Referral Date:** <TodaysDate>GP Review Date: [<GP review date>](#BPSFIELD|D|10|||)**Feedback Requested:** Yes  |

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|  |  |  |  |  |  |  |
|  | **Referral to:**Women's Health CentreBendigo Health |  |  |  | **Referring General Practitioner:**<DrName> |  |
|  |  |  |  |  |  |  |
|  | PO Box 126  |  |  |  | <Practice> |  |
|  |  |  |  |  |  |  |
|  | BENDIGO3552  |  |  |  | <UsrAddress> |  |
|  |  |  |  |  |  |  |
|  | Phone:  |  |  |  | Phone: <UsrPhone>Fax: <UsrFax> |  |
|  |  |  |  |  |  |  |
|  | Fax: 03 5454 7286 |  |  |  | Email: <PracEmail> |  |
|  |  |  |  |  |  |  |
|  | Email: womenshealth@bendigohealth.org.au |  |  |  | Provider No.: <DrProviderNo> |  |
|  |  |  |  |  |  |  |

Patient / client details

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Name: <PtFirstName> <PtSurname> |  | Address: <PtStreet> |
|  |  |  |
| Date of Birth: <PtDoB> |  | Address: <PtCity> <PtState> <PtPostcode> |
|  |  |  |
| Preferred Name/s: <PtPrefName> |  | Phone: <PtPhoneH> Work: <PtPhoneWk>  |
|  |  |  |
| Sex: <PtSex> |  | Mobile: <PtPhoneMob> |
|  |  |  |
| Title: <PtTitle> |  | Email: <PtEmail> |
|  |  |  |
|  |  |
| Alternative Contact:  | [<Alternative contact>](#BPSFIELD|C|0|||0) |
| Indigenous status: | [<ATSI Status>](#BPSFIELD|L|68|Non-indigenous|||Non-indigenous|Aboriginal|Aboriginal and TSI|Torres Strait Islander) |
| Interpreter required: [<Interpreter required?>](#BPSFIELD|L|7|No|||Yes|No) |  | DVA Number: <PtDVANo> |
| Preferred language is: [<Preferred language?>](#BPSFIELD|C|0|||0)  |  | Insurance: <PtHealthIns> |
| Pension Card Number: <PtPensionNo> |  | Medicare Number: <PtMCNo> |

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| **Consent to referral and sharing of relevant information:** |  |  Yes No |  |   |

Attach 'Patient Consent Form' if restrictions apply.

Reason for patient referral\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Current Obstetric History** |
| **LNMP:** | <<Clinical Details:LNMP>> |  | **Estimated delivery date:**  |  |
| **Gravida:** | <<Clinical Details:Gravida>> | **Parity:** | <<Clinical Details:Parity>> | **Known multiple pregnancy:** | [<<Known multiple pregnancy>>](#|B|||1|N) |
| **Height:** | [<<Height (cm)>>](#|C|0||0|) cm | **Weight:** |  [<<Weight (kg)>>](#|C|0||0|) kg | **BMI\*:** | [<<BMI>>](#|C|0||0|) | \*must be included to enable triage and booking |
| **Last PAP test:** *date & result* | [<<Last PAP test (date & result)>>](#|C|0||0|) | **Female circumcision:** | [<<Female circumcision>>](#|B|||1|N) |

<<Clinical Details:Pap Smear/ cervical screening

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  Has <PtFirstName> been a patient at this hospital before? [<Been a patient at this hospital before>](#BPSFIELD|B|10|||)

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| **Past Obstetric History** *Check if applicable*   |
|  Previous severe pre-eclampsia  |  Previous small baby <2800g |  Previous fetal abnormality (specify) |
|  Mid trimester loss OR miscarriage x 3 or more |  Previous preterm birth <35 weeks ( specify gestation\_\_\_\_) |  Previous Caesarean, how many\_\_\_\_\_ |
|  Still birth |  Placental abruption |  Gestational diabetes |
|  Other (specify) |  Rhesus isoimmunisation |  PPH >= 1000mls |

 [<Details of obstetric history>](#BPSFIELD|M|254|||)

|  |
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| **Risk Factors Relevant to Pregnancy** *Check if applicable*   |
|  Diabetes pre pregnancy  |  Cervical surgery  |  Previous cone biopsy /2 or more LLETZ procedures |
|  Heart disease  |  Anaemia |  Epilepsy  |
|  Asthma requiring admissions or oral steroids within past 12 months  |  DVT or pulmonary embolus |  Thalassemia / haemoglobinopathy |
|  Psychiatric disorders |  Hepatitis B or C |  High blood pressure/or on medication |
|  Renal disease |  SLE |  Thyroid disease |
|  **Alcohol and other substance use (specify)** |  |  Smoking |
|  Family history of genetic disease (specify) |  |

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Clinical Information

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| **Warnings:** <Comment> |
|  |
| **Allergies:** <Reactions> |
|  |

**Current Medication:**

|  |
| --- |
| <SelectedRx> |

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| **Social History:*** Protective Factors
* Mental Health concerns/Hx
* Family Violence
* Child protection issues
* Legal/ correction issues
* Psychosocial issues
* Housing
* Refugee
 |

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| **Past Medical / Surgical History:**<PMHAll> |

Pregnancy investigations

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| **Investigations /Test Results *Please fax all results with referral*** |
| **Pathology Provider:** [<<Pathology Provider>>](#|C|0||0|) |
|  FBE  |  HIV serology |  |
|  Blood group and antibodies |  MSU / urinalysis |  |
|  Rubella  |  Ferritin |  |
|  Hepatitis B  |  Syphilis serology |  |
|  Hepatitis C  |  Thalassemia testing/ Hb electrophoresis |  |
|  Consider GTT at 16 weeks: if past GDM, PCOs, BMI>35, Family history of diabetes, previous baby >4.5kg |
|  Morphology 20 week Ultrasound (please provide details of ultrasound provider) |
| **Consider:** |  |  |
|  Dating ultrasound 10-13 weeks |  Vitamin D |  Chlamydia |
|  GTT at 16 weeks: if past GDM, PCOS, BMI>35, Family history of diabetes, previous baby >4.5kg |

**Aneuploidy Screening**

Aneuploidy screening options have been discussed with the patient:  Yes  No

If yes:

 First Trimester Combined Screen (please provide details of ultrasound provider)

 Second Trimester MSST

 Non-invasive Prenatal screening using cell free DNA (please provide details of provider)

The patient has declined aneuploidy screening  Yes  No

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