**REQUEST FOR OUTPATIENT APPOINTMENT**

**OBSTETRICS ANTENATAL**

**Fiona Stanley Hospital**

F.S.H Antenatal GP Referral Form Pg 1 of 2

Please print in UPPERCASE and ensure all fields are completed prior to faxing.

**Patient Details**

|  |  |  |
| --- | --- | --- |
| **NOK Relationship** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **NOK Family Name** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **NOK Given Name** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **NOK Address** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **NOK Contact** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Have you previously been to Fiona Stanley Hospital?** | |
| ☐ Yes ☐ No | |
| **Country of Birth** |  |
| **Aboriginal/Torres Strait Islander** | |
| ☐ Yes ☐ No | |
| **Marital Status** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Interpreter:** ☐ No ☐ Yes Language\_\_\_\_\_\_\_\_\_\_ | |
| **Employment Status**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Health Care Card / Pension** | |
| **Ref No** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Expiry Date** \_\_\_\_\_\_\_\_\_\_\_ | |

|  |  |  |
| --- | --- | --- |
| **Family Name** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Given Name** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Date of Birth** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Address** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
|  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Home Contact** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Mobile Contact** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Maiden Name** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Previous Family Name** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Have you been hospitalised in the last 7 Days?** | | |
| Yes \_\_\_\_\_\_\_\_\_\_\_\_ | | No |
| **Admission Date** \_\_\_\_\_\_\_ | | **Discharge Date** \_\_\_\_\_\_\_ |
| **Medicare Number** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **Ref No** \_\_\_\_\_\_\_\_\_\_\_\_\_ | | **Expiry Date** \_\_\_\_\_\_\_\_\_\_ |

**Remember: Patients must bring their Medicare Card to their appointments**

**GP Referral Details**

**Referring GP --------------------------------------------------------**

**Surgery --------------------------------------------------------**

**Address --------------------------------------------------------**

**Phone --------------------------------------------------------**

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**OBSTETRICS ANTENATAL**

**Fiona Stanley Hospital**

**Patient Details**

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

**EDD (by dates) \_\_\_\_\_\_\_\_\_\_\_\_ EDD (by Ultrasound) \_\_\_\_\_\_\_\_\_\_\_\_**

**Weight \_\_\_\_\_\_\_\_\_\_\_\_ kgs Height \_\_\_\_\_\_\_\_\_\_\_\_ m BMI \_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |
| --- | --- |
| **Current Pregnancy:** | **Previous Obstetric History/Complications:** |
| **Allergies:** | **Significant Medical History:** |

**To ensure all women have the required Antenatal investigations we request you to order the following tests and ensure photocopies of results from the tests listed below are sent to Fiona Stanley Hospital and/or give to the patient to bring to their first Antenatal Clinic Appointment.**

☐Results Attached ☐Results with Patient ☐Results sent direct to FSH Fax

Check (X) beside those test you have the results for or if you have arranged the test.

PathWest collection centre is available at Fiona Stanley and results for tests performed at PathWest are automatically made available to staff at Fiona Stanley.

\*\*Please attend GTT early if previous history of GDM

|  |  |  |  |
| --- | --- | --- | --- |
| Full Blood Picture including Fe Studies | ☐ | Glucose Tolerance Test \*\* | ☐ |
| Group and atypical antibodies | ☐ | Midstream Sterile Urine | ☐ |
| Hep B Surface antigen / Hep C Antibodies | ☐ | Pap (within 2 years) | ☐ |
| HIV antibodies | ☐ | Early dating ultrasound (if dates uncertain) | ☐ |
| Rubella antibodies | ☐ | 1st trimester screen (11-13wks) or 2nd trimester maternal serum screening (15-17 wks) | ☐ |
| Syphilis antibodies | ☐ | Fetal anatomy U/S 18 to 20 wks | ☐ |
| Chlamydia | ☐ | Iron Studies | ☐ |
| TFT | ☐ | Vitamin D | ☐ |
| Other | ☐ |  |  |

F.S.H Antenatal GP Referral Form Pg 2 of 2

**Please send this completed form to: Fiona Stanley Referral Service FAX 6152 9762**  
 (One patient per fax)