Expected Pathways of Care for pregnant women

FMAC (Fetal Maternal Assessment Clinic) Referral Form

For the assessment of problems in later pregnancy not requiring urgent care

easternhealth
GREAT HEALTH AND WELLBEING

I Identification *Referring clinician:*

Name_____Designation_____

Phone _____Fax _____

- ***Phone FMAC to discuss an appointment***
- ***File this form in the woman's handheld record***

Interpreter Required: ☐ Yes ☐ No

Language: _____

BRADMA LABEL

UR No:
Surname:
Given Name:
Address:
Phone No:
D.O.B. ___/___/_____

☐ **Angliss Hospital FMAC** *(Monday - Friday 0830 – 1700 hrs)* **Phone 9759 1865 Fax 9764 6193**
☐ **Box Hill Hospital FMAC** *(Monday - Friday 0830 – 1700 hrs)* **Phone 9895 4677 Fax 9895 3877**
☐ **Yarra Ranges Health FMAC** *(Wed only 0830 – 1700 hrs)* **Phone 8706 9710 Fax 9091 8899**

S Situation *Reason for referral:* ☐ NON URGENT ☐ URGENT Date ___/___/_____

O Observation *e.g. BP, proteinuria, FHR*

B Background

Gravida____ Para_____

Current Pathway ☐ Green ☐ Red Gestation _____ *wks*

Underlying Medical Condition/s_____

Current Obstetric Compilcation/s_____

A Assessment *(tick boxes)*

☐ Routine 41/40 Assessment
☐ Routine Anti D prophylaxis
☐ Fetal growth SGA
☐ Fetal growth LGA
☐ Decreased Fetal Movements
☐ Abnormal test result _____
☐ Abnormal observation parameter _____
☐ Abnormal fetal presentation / lie _____
☐ Other *(specify)* _____

R Request from referring clinician *(tick boxes)* : ☐ CTG ☐ US ☐ AFI ☐ ANTI D ☐ ECV

☐ 4/24 STAY for_____ ☐ Registrar Review for _____

Response Clinician (FMAC): Name_____ Designation_____

For external referrals, complete details and fax this form to the referring clinician after her attendance in FMAC

Result / Recommendation _____

_____

_____

Ongoing Maternity Care Pathway ☐Green ☐Red To birth at _____Hospital