Expected Pathways of Care for pregnant women

Obstetric / Maternity Specialised Clinic Referral Form

For referring women to a specialised clinic where urgent care is not required

easternhealth
GREAT HEALTH AND WELLBEING

I **Identification** *(Referring clinician)*

Name_____

Designation _____ Phone _____

Patient's preferred phone number_____

Interpreter Required: ☐ Yes ☐ No

Language _____

BRADMA LABEL

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

S **Situation** (*Reason for referral*): Date of referral: ___/___/_____

Urgency rating: Within ☐ 2 days ☐ 1 week ☐ 2 weeks ☐ 4 weeks ☐ 6 weeks

O **Observation** *(Clinical details):*

B **Background** ☐Inpatient ☐Outpatient Booked / Birthed at: ☐Box Hill ☐Angliss

Partner name _____ Baby Name *(if applicable)*_____

Medical History _____

Significant O&G History _____

Social History_____

A **Assessment**

☐ **Perinatal Review for:** **Maternal Reports:** **Fetal Reports:**	☐ Stillbirth / FDIU ☐ Pre-Eclampsia ☐ Shoulder Dystocia ☐Fetal Abnormality ☐ Maternal Medical/ Intrapartum ☐ Other – See notes ☐Haematology ☐Microbiology ☐Histopathology ☐Viral Serology ☐Autopsy ☐Chromosomes ☐ Other
☐ **Perineal Clinic** *at Box Hill*	☐ 3rd / 4th deg tear ☐Incontinence ☐Other ***Angliss referrals – scan form and email to PerinealClinic@easternhealth.org.au***
☐ **High Risk Obstetric Clinic**	☐High Risk Obstetrician ☐High Risk Registrar ☐Renal Obs / Med Consultant ☐Obs / Med Registrar ☐Haematologist / Obs Med Consultant
☐ **Endocrine Clinic**	☐IDDM ☐Type 2 Diabetes ☐GDM ☐Thyroid
☐ **SMS (Specialised Maternity Service)**	☐Mental Health ☐Drug & / or Alcohol ☐Complex Social Issues

R **Referral to:** ☐**Box Hill Hospital** ☐ handed to clerical staff in ANC ☐faxed to ANC **9895 4644**

☐**Angliss Hospital** ☐ faxed to 3 West Clerk **9764 6193**

Appointment: Date ___/___/_____ Time_____ Clinic _____

☐ Patient notified of appointment ☐ by Phone ☐ by Letter

Form sent to: ☐ HIS for scanning ***N.B for SMS – please leave a copy for the SMS midwife***