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| GP Referral  to 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 Centre  Bendigo Health |  |  |  | **Referring General Practitioner:**  <DrName> |  |
|  |  |  |  |  |  |  |
|  | PO Box 126 |  |  |  | <Practice> |  |
|  |  |  |  |  |  |  |
|  | BENDIGO  3552 |  |  |  | <UsrAddress> |  |
|  |  |  |  |  |  |  |
|  | Phone: |  |  |  | Phone: <UsrPhone>Fax: <UsrFax> |  |
|  |  |  |  |  |  |  |
|  | Fax: 03 5454 7286 |  |  |  | Email: <PracEmail> |  |
|  |  |  |  |  |  |  |
|  | Email: womenshealth@bendigohealth.org.au |  |  |  | Provider No.: <DrProviderNo> |  |
|  |  |  |  |  |  |  |

Patient / client details

|  |  |  |  |  |
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|  | |  | |  |
| 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|||)   |  |  |  | | --- | --- | --- | | **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|||)   |  |  |  |  | | --- | --- | --- | --- | | **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) | |  | | | |

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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