

ANTENATAL REFERRAL FORM to Central Hospital Network - St George or Sutherland Hospital

Information about your health and wellbeing will be collected and be available to both the hospital and your GP unless otherwise requested.

Woman to complete this section

Surname:		Given Names:	
Previous/Maiden Name:		Occupation:	
Date of Birth:	Medicare card no:	Exp date:	
Marital status: <input type="checkbox"/> Widow <input type="checkbox"/> Never married <input type="checkbox"/> Married/De facto <input type="checkbox"/> Separated <input type="checkbox"/> Divorced			
Country of Birth:		Religion:	
Language used at home:		Interpreter needed: Yes <input type="checkbox"/> No <input type="checkbox"/>	
Aboriginality: Yes <input type="checkbox"/> No <input type="checkbox"/>		Torres Strait Islander: Yes <input type="checkbox"/> No <input type="checkbox"/>	
Billing Status: Overseas (no Medicare) <input type="checkbox"/> Reciprocal <input type="checkbox"/> Medicare <input type="checkbox"/>		Fund Name:	
Private insurance: Top <input type="checkbox"/> Basic <input type="checkbox"/> Nil <input type="checkbox"/>		Fund No:	
Home Address		Person to contact	
Street:		Name:	
		Relationship:	
Suburb:		Street:	
State:	P/code:	Suburb:	
Phone no: (h)		State:	P/code:
(w)	(Mob)	Phone no:	

Have you previously attended St George Hospital before?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Have you previously attended Sutherland Hospital before?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If Yes, under what surname?	
Have you previously received pregnancy care at St George (<input type="checkbox"/>) or Sutherland (<input type="checkbox"/>) Hospitals? If so, which clinic did you attend?	
Would you like the same care for this pregnancy?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(Below are for low risk, no drugs options of care)	
Are you interested in the St George Birth Centre for your pregnancy care?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Are you interested in the St George Home Birth program with a midwife for pregnancy care?	Yes <input type="checkbox"/> No <input type="checkbox"/>

USEFUL PHONE NUMBERS

Sutherland Hospital
 Main Switchboard 9540 7111
 Antenatal Clinic 9540 7240
 Appointment Enquiries ~ Mon - Fri 9 am - 4.30 pm
 Antenatal Assessment Unit 9540 8654
 Clinical Enquiries ~ Mon to Friday 8.30 am - 4.30 pm
 Birthing Suite 9540 7982/7981

St George Hospital
 Main Switchboard 9113 1111
 Birth Centre 9113 3103
 Antenatal Clinic 9113 2162
 Delivery Suite 9113 2126
 St George Bookings/Info 9113 2162 from
 8.30am - 3.30 pm Mon to Thurs & 8.30am - 12.00 pm Fri

PLEASE RETURN COMPLETED FORM TO:

Antenatal Booking Clerk
 Sutherland Hospital
 Locked Bag 21, Taren Pt NSW 2229
 or fax to 9540-7304

OR

Antenatal Booking Clerk
 St George Hospital
 Gray Street, Kogarah NSW 2217
 or fax to 9113-3765

to receive your appointment

ANTENATAL REFERRAL FORM to Central Hospital Network - St George or Sutherland Hospital

GP STAMP: Fax No: Ph: No: Provider No:	THIS WOMAN IS TO RETURN TO ME FOR SHARED CARE? Yes <input type="checkbox"/> No <input type="checkbox"/>
	GP Signature: _____ Date: ___ / ___ / ___

When offering Nuchal Translucency Plus testing - please counsel and organise before 12 weeks gestation or ensure early referral to the Antenatal Clinic.

I wish to share my pregnancy care with my GP and the hospital clinic(s). I understand that this involves sharing personal and health information between these two services.

Name _____ **Signature** _____ **Date** ___ / ___ / ___

NAME _____

L.M.P _____ **Age** _____

E.D.C _____

Gravida _____ **Para** _____

PRESENT PREGNANCY:

	Yes	No
Nausea / vomiting	<input type="checkbox"/>	<input type="checkbox"/>
PV bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>

Current Medications _____

Drugs of Addiction _____

Cigarettes -no / daily _____

Alcohol - gm / week _____

Allergies _____

PREVIOUS OBSTETRIC HISTORY:

FAMILY HISTORY:

	Yes	No
Cardiac	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>
Twins	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>
Other congenital abnormalities	<input type="checkbox"/>	<input type="checkbox"/>

Specify _____

❖ Interpreter needed? **Yes** **No**

❖ Language required: _____

EXAMINATION:

BP ___ / ___ at ___ weeks gestation

Abdomen _____ Heart _____

Lungs _____ Thyroid _____

Breast examination _____

Other findings:

MEDICAL HISTORY:

	Yes	No
Cardiac	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Infertility	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Sexually Transmitted Infections	<input type="checkbox"/>	<input type="checkbox"/>
Transfusions	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>
Depression/Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Renal	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>

Other past History _____

SOCIAL HISTORY: _____

Please ensure the following results are available: (And a copy to be sent to the Antenatal Clinic/Birth Centre)

Blood group & antibody screen	<input type="checkbox"/>
Full blood count	<input type="checkbox"/>
Haemoglobin EPG (as per hospital guidelines)	<input type="checkbox"/>
Rubella IgG	<input type="checkbox"/>
Varicella IgG	<input type="checkbox"/>
Syphilis (ELISA)	<input type="checkbox"/>
Hepatitis B (surface antigen)	<input type="checkbox"/>
MSU for M/C/S	<input type="checkbox"/>
Pap Smear	<input type="checkbox"/>
HIV/Hep C (offered with counselling)	<input type="checkbox"/>

Pathology Laboratory _____

18 weeks ultrasound booked: **Yes** **No**

Genetic counselling arranged **Yes** **No**

NT Plus/CVS/Amnio arranged **Yes** **Declined**

(please circle)

Not discussed Please specify _____