



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 #:	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"/>	
Private insurance: Top <input type="checkbox"/> Basic <input type="checkbox"/> Nil <input type="checkbox"/> Fund Name:		Fund No:	
Billing Status: Overseas (no Medicare) <input type="checkbox"/> Reciprocal <input type="checkbox"/> Medicare <input type="checkbox"/>			
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 attended this Hospital before?		Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, under what surname? _____	
Would you like Shared Pregnancy Care with your GP & the hospital? <i>(Shared Care involves alternating visits with your GP and the hospital clinics)</i>		Yes <input type="checkbox"/> No <input type="checkbox"/>	

Have you previously received pregnancy care at the Royal Hospital for Women? **Yes** **No**

If yes, please tick the type of care received Birth Centre Antenatal Clinic

Would you like the same care for this pregnancy? **Yes** **No**

What is your preferred appointment time for your hospital pregnancy care? **am** **pm**

Are you interested in the Birth Centre for your pregnancy care? **Yes** **No**

📞 USEFUL PHONE NUMBERS

Hospital 9382 6111
 Birth Centre 9382 6116
 Antenatal Clinic 9382 6446
 Bookings/Enquiries 9382 6048
 Enquiries 8.30-4.00 Monday-Thursday

PLEASE BRING THIS COMPLETED FORM TO YOUR FIRST ANTENATAL/BOOKING IN APPOINTMENT AT THE ROYAL HOSPITAL FOR WOMEN



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

Antenatal Clinic Consultants: Prof. Bennett, Dr Buist, Dr Challis, Dr Coogan, Dr Hawke*, Dr Horowitz, Dr Leader, Dr Lee*, Dr Nand*, Dr Sen, Dr Teoh, and Prof. Welsh *female

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 <input type="checkbox"/> No <input type="checkbox"/>
Genetic counselling arranged	Yes <input type="checkbox"/> No <input type="checkbox"/>
NT Plus/CVS/Amnio arranged	Yes <input type="checkbox"/> Declined <input type="checkbox"/>
(please circle)	
Not discussed <input type="checkbox"/>	Please specify _____
