

ANTENATAL BOOKING 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"/>	
Pre-pregnancy Weight: _____ Kg		Height: _____ cm	
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"/>
<i>(Below are for low risk, no drugs options of care)</i>	
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	
<u>Sutherland Hospital</u>	
Main Switchboard	9540 7111
Antenatal Clinic	9540 7240
Appointment Enquiries: Mon - Fri	9am - 4.30pm
Antenatal Assessment Unit	9540 8654
Clinical Enquiries: Mon - Fri	8.30am - 4.30pm
Birthing Suite	9540 7982/7981
<u>St George Hospital</u>	
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-3.30pm Mon to Thurs & 8.30am-12.00pm 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
<i>to receive your appointment</i>	

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

GP Name: _____ Practice Name: _____ Practice Address: _____ _____ Fax No: _____ Ph: No: _____ Provider No: _____	THIS WOMAN IS TO RETURN TO ME FOR <u>SHARED CARE</u>? 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** ___/___/___

<p>NAME _____</p> <p>L.M.P _____ Age _____</p> <p>E.D.C _____</p> <p>Gravida _____ Para _____</p> <p>PRESENT PREGNANCY:</p> <table style="width:100%;"> <tr> <td></td> <td style="text-align: center;">Yes</td> <td style="text-align: center;">No</td> </tr> <tr> <td>Nausea / vomiting</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>PV bleeding</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Abdominal pain</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table> <p>Current Medications _____</p> <p>Drugs of Addiction _____</p> <p>Cigarettes -no / daily _____</p> <p>Alcohol - gm / week _____</p> <p>Allergies _____</p> <p>PREVIOUS OBSTETRIC HISTORY:</p> <p>_____</p> <p>_____</p> <p>FAMILY HISTORY:</p> <table style="width:100%;"> <tr> <td></td> <td style="text-align: center;">Yes</td> <td style="text-align: center;">No</td> </tr> <tr> <td>Cardiac</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Diabetes</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Hypertension</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Twins</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Hepatitis B</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Other congenital abnormalities</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table> <p>Specify: _____</p> <p>❖ Interpreter needed? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>❖ Language required: _____</p> <p>EXAMINATION:</p> <p>BP _____/_____ at _____ weeks gestation</p> <p>Abdomen _____ Heart _____</p> <p>Lungs _____ Thyroid _____</p> <p>Breast examination _____</p> <p>Weight _____ BMI _____</p> <p>Other findings: _____</p>		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"/>		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"/>	<p>MEDICAL HISTORY:</p> <table style="width:100%;"> <tr> <td></td> <td style="text-align: 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<p>18 weeks ultrasound booked Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Genetic counselling arranged Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>NT Plus / CVS / Amnio arranged Yes <input type="checkbox"/> Declined <input type="checkbox"/></p> <p><i>(Please circle)</i></p> <p>Not discussed <input type="checkbox"/> <i>Please specify</i> _____</p> <p>_____</p>		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 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