Government of Western Australia
Department of Health

REQUEST FOR OUTPATIENT APPOINTMENT
Obstetrics & Gynaecology

Surname:
First name:
DOB:

Referral To

(URGENT/IMMEDIATE REFERRALS ARE NOT SENT TO CRS, SEND DIRECTLY TO HOSPITAL)

- ☐ Antenatal Clinic
- ☐ Fertility
- ☐ Menopause
- ☐ Gynaecology
- ☐ Colposcopy
- ☐ Genetic Services
- ☐ Oncology
- ☐ CVS/Amino
- ☐ Other:
- ☐ Ultrasound
- ☐ Urogynaecology

Name of Specialist (if required):

Site:

Referral From

Name:

Provider Number:

Phone: **Fax:**

Address:

Once completed, please send referral to the ***Central Referral Service*** by one of the following methods. Please note that for efficiency of process our preferred method is ***Secure Messaging***.

Secure Messaging	See the CRS website for more information on available vendors. http://ww2.health.wa.gov.au/Articles/N_R/Referral-form-templates
Fax	1300 365 056
Post	Central Referral Service PO Box 3462 Midland WA 6056

Patient Details

URMN Hospital No: (if known)

First Name(s): **Family Name:**

Preferred Name: **Previous Name (e.g. Maiden):**

Title: **Marital Status:**

Country of Birth: **Birth Date:**

Gender: Please select

ATSI Status: Please select

Address: **Mailing Address (if different):**

Post code: **Email:**

Telephone No:

Home: **Work:**

Mobile: **Fax:**

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Special Needs:
Is an interpreter required? ☐ **If Yes, language/Dialect:**

Other Special needs:

Medicare Eligible: ☐ **Medicare No:** **Ref**: **Expiry:**

DVA Card Number: **DVA Card Type:**

MVIT ☐ **Workers Compensation** ☐

Next of Kin/Guardian

Full Name:

Relationship: **Phone:**

Referral Details

Fill this box for Immediate Referrals only *(if the Patient must be seen by specialist within 7 days)*
Has the referral been discussed with Registrar or Consultant? ☐ **(essential for Urgent Cases)**
If yes, the clinician name:

Site: **Contact Number:**

Referral advice given:

Is the referrer the usual GP for the patient? ◯ **YES** ◯ **NO**

If No, name of usual GP:

Contact number:

If the patient has been referred to this speciality for the same condition before, do they need to be referred to the same place again? ◯ **YES** ◯ **NO**

Is the patient suitable for a Telehealth consult? ◯ **YES** ◯ **NO**

Length of Referral: ◉ **3mths** ◯ **12mths** ◯ **Indefinite**

Is this a renewed referral? ◯ **YES** ◯ **NO**

If Obstetric Patient:
We would like to share antenatal care with you, both before and after the first clinic visit (usually at 20 weeks).
I Please se wish to be involved in shared care.

Reason for referring:

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Clinical Information		
Obstetric History:		
Gravida:	**EDD (by dates):**	**EDD (by scan):**
Parity:	**Multiple Pregnancy:**	**DCDA:** ☐
LMP:	**Twins:** ☐	**MCDA:** ☐
	Other: ☐	**MCMA:** ☐
Observations	**BMI:** **Height:**	**Weight:**
Current Problem:		
Past History:		
Current Medications:		
Allergies:		
Other:		
Family:		
Social History:		

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Relevant Antenatal Investigations and Tests

Please include photocopies or arrange for copies of results of tests to be sent to the hospital. Nominate the test results you have arranged or will arrange: Please refer to CPAC guidelines for non-obstetric referrals

☐	***Full Blood Picture***	☐ ☐	***Pap (within 2 years)*** ***Pap (abnormal)***
☐	***Blood Group and Antibody Screen***	☐	***Midstream Sterile Urine/MC&S***
☐	***Rubella IgG Serology***	☐	***Early Dating Ultrasound (if dates uncertain)***
☐	***Chlamydia Screening***	☐	***1st Trimester screen (11-13 weeks) or Maternal serum screening (15-17 weeks)***
☐	***Syphilis Serology***	☐	***Fetal Anatomy U/S (18-20 weeks)***
☐	***Hep B Surface Antigen***	☐	***Pelvic Ultrasound (non obstetric referrals)***
☐	***Hep C Serology***	☐	***Glucose Tolerance Test routing (24-28 weeks)***
☐	***HIV Serology***		***If high risk for GDM please do early OGTT.***
☐	***Vitamin D***		
☐	***Haemoglobinopathy***		

Other:

Pathology Provider: **Radiology Provider:**

Indicate Specialist service/s that you believe need to see this patient before 20 weeks, please state reason:

☐	***Genetic Services***	☐	***Diabetes***
☐	***Adolescent***	☐	***Ultrasound***
☐	***Obstetric Medicine***	☐	***Drug & Alcohol***
☐	***Maternal Fetal Medicine (high risk)***	☐	***Dietician***
☐	***Psychology***	☐	***Social Work***

Other:

Reason:

Doctor Name: **Provider Number:**

Designation: **Date:**

Hospital Use Triage Only:

Urgent: Semi Urgent: Routine:
Comments:
Name: Signature: Date: