Antenatal Referral Form

Date of Referral: _____

ALL Antenatal Referrals are to be faxed directly to KEMH via fax **(08) 6458 1031** unless specified below.

Referring practitioner details

Name: _____ Provider number: _____

Practice address: _____

Practice telephone number: _____ Practice fax: _____

Health link details: _____

Are you able to provide shared antenatal care for this patient if KEMH determines her to have a low risk pregnancy? ☐ Yes ☐ No

Patient details

Full name: _____ Preferred name: _____

Known by another name? _____

DOB: _____ Gender: _____ ATSI status: _____

Address: _____

Mail address (if different): _____

Email: _____ Main telephone number: _____

Mobile: _____ Work: _____ Home: _____

Medicare Number: _____ Country of birth: _____

If no Medicare, please input Private Fund details: _____

URMN Hospital no. if known: _____

Interpreter needed: ☐ Yes ☐ No Language & dialect: _____

Patient details continued →

Patient details (continued)

Special needs:

Next of Kin / Guardian

Full name: _____

Relationship: _____ Phone no: _____

Referral details

Does this patient need to be seen within 7 days? ☐ Yes ☐ No

Is this patient suitable for Telehealth consult? ☐ Yes ☐ No

Which consultant / registrar was this discussed with

Name: _____ Site: _____ Date: _____

Are you requesting **pre conception care**? ☐ Yes ☐ No

please indicate specialist clinic requested: _____

This pregnancy

LMP: _____ Estimated date of delivery: _____

Confirmed by ultrasound ☐ Yes ☐ No Date: _____

Gravida: _____ Para: _____

Weight: _____ Height: _____ BMI: _____ BP: _____

Referral details continued →

Referral details (continued)

Significant past obstetric history ☐ Yes ☐ No

If yes, please detail below and include previous pregnancies and outcomes:

For the **current pregnancy**, are there any clinical concerns requiring specialist care?

Significant past medical history ☐ Yes ☐ No

If yes, please detail below:

Current medications:

Medication allergies:

Cervical screening test current ☐ Yes ☐ No ☐ Not applicable

Results of antenatal tests attached ☐ Yes ☐ No

Results of ultrasounds attached ☐ Yes ☐ No

Models of pregnancy care and birth options

Patient name: _____ D.O.B: _____

Please indicate which model of care is requested

☐ 1. GP led Antenatal Shared Care with KEMH

GP provides low risk women (as determined by KEMH at 20 weeks visit) with antenatal care in first two trimesters of pregnancy, and women are then seen at KEMH at 36 weeks to plan further care.

Support is available during the pregnancy should concerns arise.

☐ 2. Community midwifery programme

Do not send referral to KEMH. Patient to apply directly via
https://kemh.health.wa.gov.au/For-patients-and-visitors/Pregnancy-Patients/Community-Midwifery-Program

3. Midwifery group practice

☐ a) Hospital based Midwifery Group Practice or previous MGP if known

or

☐ b) Family Birth Centre - *Do not send referral to KEMH*

Patient to apply directly via
https://kemh.health.wa.gov.au/For-patients-and-visitors/Pregnancy-Patients/Family-Birth-Centre

☐ 4. Hospital Midwifery Led antenatal Clinics

☐ 5. Obstetrician led antenatal care

This model of care is for women who have: indicate which applies

☐ complicated medical history

☐ previous pregnancy requiring specialist obstetric care

☐ pregnancy that is not progressing normally

☐ multiple pregnancy

Specialist Antenatal Clinics requested

Patients may be referred to more than one clinic if needed using this form

Patient name: _____ D.O.B: _____

1. Maternal fetal medicine team

All referrals for MFM go direct to unit via fax **08 6458 1060**

The MFM clinic is for women with complex high risk pregnancies (maternal and fetal disorders / diseases). Women may also be referred for preconception counselling & planning. Referrals relating to high risk pregnancies are triaged in the MFM Department, please include detailed information above.

2. Ultrasound / Imaging Services

☐ CVS ☐ Amniocentesis ☐ Ultrasound

☐ Fetal Anomaly

3. Childbirth and Mental Illness Service (CAMI Clinic)

please indicate which applies

☐ Schizophrenia ☐ Bipolar Disorder

☐ Prior history of Post Partum Psychosis

4. Women and Newborn Drug and Alcohol Service (WANDAS)

☐ Alcohol ☐ Other drug use

☐ Both

5. Diabetes Clinic

☐ Type 1 insulin dependent diabetes

☐ Type 2 diabetes

☐ Gestational Diabetes <20 weeks

☐ Preconception counselling

6. Adolescent and Young Women's Clinic

Age <19 years at expected date of delivery

☐ Yes

7. Physicians Clinic

☐ Preconception counselling

☐ Medical review during pregnancy

Which hospital is patient booked to deliver at?

_____

☐ 8. Placenta Accreta Clinic

For suspected placenta accreta, percreta or increta please provide copies of ultrasounds & detailed obstetric history

9. Preterm Birth Prevention Clinic

Please indicate if history of

☐ preterm birth before 34 weeks gestation

☐ uterine anomaly

☐ significant cervical intervention

☐ perinatal loss between 16-24 weeks

10. Genetic Services

☐ Yes ☐ No

11. Additional services required

☐ Social work

☐ Psychological medicine

☐ Dietitician

Antenatal first trimester routine tests required with this referral

Please include photocopies or arrange for copies of results of tests to be sent to the hospital.
Please indicate which tests you have arranged.

- ☐ Full Blood Picture
- ☐ Blood Group and Antibody screen
- ☐ Hepatitis B surface antigen
- ☐ Hepatitis C antibodies
- ☐ HIV antibodies
- ☐ Syphilis serology
- ☐ Rubella IgG serology
- ☐ Midstream urine mc&s
- ☐ Chlamydia / Gonorrhoea screening
  - Self Obtained Low Vaginal Swab (SOLVS)
- ☐ Cervical screening Test (CST) within 5 years
- ☐ Early dating ultrasound (if dates uncertain)

If patient has relevant risk factors:

- ☐ Gestational Diabetes - Early Oral Glucose Tolerance Test
- ☐ Vitamin D screening
- ☐ Haemoglobinopathy screening

Fetal anomaly screening offered

Testing performed: ☐ Yes ☐ No *Please forward results of testing:*

- ☐ a) Combined test = First trimester biochemistry (9-13+6 weeks) AND Nuchal translucency Ultrasound (11-13+6 weeks)

OR

- ☐ b) NIPT blood test (8 weeks) AND Nuchal translucency Ultrasound (11–13+6 weeks)

OR

- ☐ c) Second trimester screen if first trimester screen missed = NIPT preferred but maternal serum screen available as blood test at 15-17 weeks

☐ **Fetal Anatomy ultrasound scan at 18-20 weeks**
(Please fax through results to 6458 1031)

HealthyWA
healthywa.wa.gov.au

This document can be made available in alternative formats on request.

Women and Newborn Health Service
King Edward Memorial Hospital
374 Bagot Road, Subiaco WA 6008
Telephone: (08) 6458 2222
www.kemh.health.wa.gov.au

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