**WNHS Antenatal Referral**

**Referral Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Referral to**

***DO NOT SEND TO* CRS. *SEND DIRECTLY TO:***

[***KEMH.Referrals@health.wa.gov.au***](mailto:KEMH.Referrals@health.wa.gov.au) ***(for KEMH/OPH antenatal referrals)***

[***KEMH.FamilyBirthCentreReferrals@health.wa.gov.au***](mailto:KEMH.FamilyBirthCentreReferrals@health.wa.gov.au?subject=Family%20Birth%20Centre) ***(for Family Birth Centre)*** [***cmp.wchs@health.wa.gov.au***](mailto:cmp.wchs@health.wa.gov.au) ***(for Community Midwifery Program)***

**Note: patient self-referrals are accepted to Aboriginal Midwifery Group Practice,** **Community Midwifery Program, Family Birth Centre**

Please send completed referral to local maternity service by 12-14 weeks gestation for routine referrals.

**Name of Maternity Service:**

Preferred maternity hospital/service: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Is this hospital within patient’s catchment?  Yes  No  
If *No*, please explain reason for preference (e.g., previous experience, relocating home address): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Preferred Model of Care**:

Who is expected to provide ongoing antenatal care?  
 Hospital – maternity care

Hospital – continuity-of-care model  
 Shared care with GP (GP agrees and is eligible)  
 GP or private midwife – with hospital input only if needed  
 Undecided / needs discussion

**Reason for referral to hospital (select all that apply):**

Full transfer of maternity care

Early obstetric assessment (e.g., risk factor evaluation, screening)

Review by specialist clinic only (e.g., MFM, CAMI, Diabetes, etc.)

Second opinion or advice only

Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Referring practitioner details**

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Provider Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Practice Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Practice Fax:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Practice Email:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Practice address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If you are not a GP, please indicate your profession:**

**EPPM**  **Nurse Practitioner**  **Other (please specify):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If your patient is eligible and consents to you sharing maternity care, are you able to provide shared maternity care with the receiving hospital?  Yes  No

**Patient details**

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

**Preferred Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Title:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Gender:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Country of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Aboriginal Status:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Address:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mail address if different:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Email:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mobile:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Home:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Work:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medicare No:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Ref:** \_\_\_\_\_\_\_\_\_**Expiry:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If Medicare ineligible, please indicate visa status:**

Visitor visa  Medical Treatment Visa  Temporary Work Visa  Working Holiday Visa

Student Visa  Temporary Graduate Visa  Bridging Visa  Business/Investment Visa

Partner Visa  Unknown

**URMN Hospital No: (if known)**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Special needs:**

**Is an interpreter required?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If Yes, Language/Dialect:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Other Special needs:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Next of Kin/Guardian**

**Full Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship:** \_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_

**Referral details**

**Urgency of Referral**

Urgent (within 7 days)

Semi-urgent (within 2 weeks)

Routine (by 20 weeks gestation)

Reason for urgency (if applicable):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Has the referral been discussed with the Registrar or Consultant?** \_\_\_\_\_\_\_\_\_\_\_\_

**If yes, the clinician’s name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Site:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Referral advice given:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Is the referrer the usual GP for the patient?**  Yes  No

**If No, name of usual GP:** \_\_\_\_\_\_\_\_\_\_\_\_\_**Contact number:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Is patient suitable for telehealth consult?**  Yes  No

**Clinical information**

**Gravida:**  \_\_\_\_\_\_\_\_\_\_\_\_\_

**Parity:** \_\_\_\_\_\_\_\_\_\_\_\_\_

**Observations**

**BMI:** \_\_\_\_\_\_\_\_\_\_\_\_\_ **Height:** \_\_\_\_\_\_\_\_\_\_\_\_\_ **Weight:** \_\_\_\_\_\_\_\_\_\_\_\_\_ **BP:** \_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you requesting preconception care?**  Yes  No **If so which clinic/s:**

Diabetes  Pregnancy Medicine  Mental Health  Pre-term birth  Perinatal Loss

Maternal Fetal Medicine

**Or, This pregnancy for maternity care:**

**LMP:**  \_\_\_\_\_\_\_\_\_\_\_\_\_

**EDD (by dates):** \_\_\_\_\_\_\_\_\_\_\_\_\_ **EDD (by Scan):**\_\_\_\_\_\_\_\_\_\_\_\_\_

**Multiple Pregnancy:**

**Twins:** \_\_\_\_\_\_\_\_\_\_\_\_ **DCDA:** \_\_\_\_\_\_\_\_\_\_\_\_\_

**MCDA:** \_\_\_\_\_\_\_\_\_\_\_\_\_

**MCMA:** \_\_\_\_\_\_\_\_\_\_\_\_\_

**Other:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Concerns for current pregnancy:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Obstetric history:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Risk Factors**

**Gestational Diabetes risk factors:**

*See* [*ADIPS 2025 guideline*](https://www.kemh.health.wa.gov.au/For-Health-Professionals/Gynaecology/Perineal-Care) *if risk factors HbA1C testing required*:

BMI >35  Previous GDM  PCOS  Age ≥ 40  FHx Diabetes  Prev LGA or Baby >4kg  Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pre-eclampsia risk factors:**

Previous pre-eclampsia,  Chronic HT  Age ≥ 40  BMI >35 Multiple pregnancy

Diabetes  Renal disease  Other (please specify)

If patient is 12-16 weeks, has the patient commenced Aspirin?Yes  No

**Preterm birth prevention:**

Previous preterm birth before 35 weeks gestation  Uterine Anomaly

Perinatal Loss between 16-24 weeks  Significant Cervical Intervention (e.g. LLETZ, cone biopsy, cerclage, cervical tear): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Vaginal progesterone pessary commenced:  Yes  No

**Previous medical & surgical history:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current medications:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Other:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Additional Information or Referral Concerns:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Routine antenatal investigations and tests required**

Please attach copies of test results and send to relevant site. If unable to attach reports, please include relevant information/findings below and advise where (provider) investigation/imaging was completed. *Please forward any subsequent results directly to the relevant site.*

**Results of antenatal tests attached:** Yes  No

**Results of ultrasound attached**: Yes  No

**Are results available on MyHealthRecord:** Yes  No

**Pathology provider:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Radiology Provider:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Booking Bloods and First Trimester Investigations**

Please indicate which tests you have arranged:

|  |  |
| --- | --- |
| Blood Group and Antibody screen  Full Blood Picture  Ferritin  Hepatitis B Surface Antigen  Hepatitis C antibodies  HIV Serology | Syphilis serology (booking)  Chlamydia, Gonorrhoea Screening  Self Obtained Low Vaginal Swab (SOLVS)  Midstream urine MC&S  Rubella IgG Serology  Cervical Screening Test (CST) within 5 years |

**If indicated on clinical history:**

☐ Thyroid Stimulating Hormone

☐ Vitamin B12

☐ Haemoglobinopathy

☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If patient has relevant risk factors:**

Gestational Diabetes – see [ADIPS 2025 Consensus guidelines](https://www.adips.org/gdm-diagnosis-and-screening-guidelines.asp). Attach investigation results to referral.

Early Dating ultrasound (if dates uncertain)

**Fetal Anomaly Screening Offered**

Testing performed:  Yes  No

*If No - order early anatomy ultrasound 11-13+6 weeks*.

Combined First Trimester screen: Maternal biochemistry (9-13+6 weeks), AND early anatomy ultrasound (11-13+6 weeks)

**OR**

NIPT Blood Test (10 weeks) AND Early Anatomy Ultrasound (11-13+6 weeks)

**OR**

Maternal Serum Screening (15-17 weeks) (if First Trimester Screen missed)

**18-20 week Investigations** (Refer early and please forward results when available)

*Consider providing request form during first trimester to allow ultrasound appointment scheduling*

Testing performed:  Yes  No

Fetal Anatomy Ultrasound (18-20 weeks)

Anatomy ultrasound cervix length:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Transabdominal  Transvaginal

Low lying placenta:  Yes  No

Fetal anomaly identified:  Yes  No. If yes, please provide details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FOR LATE PRESENTATION AND REFERRALS**

**20-28 week Investigations**

Glucose Tolerance Test routine (24-28 weeks)

Full Blood Picture (24-28 weeks)

Ferritin (28 weeks)

Syphilis serology (28weeks)

If RhD negative, then RhD NIPT at 20-26 weeks (ideally if using PathWest can be done until 32 weeks – other laboratories may have different tests and timeframes)

**Specialist Antenatal Clinics requested** (if relevant)

Does this patient require specialist antenatal service/s? If so, please indicate services requested and provide reason below:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Maternal Fetal Medicine (high risk maternal and fetal disorders / diseases)

Young Women and Adolescent Clinic (age <18 years at EDD)

Obstetric Medicine

Diabetes Clinic KEMH (Pre-existing Type 1 & 2 Diabetes)   
 Childbirth and Mental Illness Service (CAMI Clinic)

Women and Newborn Drug and Alcohol Service (WANDAS)

Preterm Birth Prevention Clinic

Additional services required (Physiotherapy, Dietician, Social Work, Psychology)