**WNHS Antenatal Referral**

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

**Referral to**

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

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

***KEMH.FamilyBirthCentreReferrals@health.wa.gov.au*** ***(for Family Birth Centre)*** ***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)