**BAC Clinic Referral**

**BAC**

**CLINIC**

**REFERRAL**

**c210043**

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| **Referral date** | |  | | | | | | | | | | | | | | |
| **Referrer** | | Name: | | | | | | | | | Designation: | | | | | |
| Phone: ( ) | | | | | | Mobile: | | | | | | | Fax: | |
| **Maternity Booking form** | | Attached  Previously sent | | | | | | | | | | | | |  | |
| **MATERNITY STATUS** | | | | | | | | | | | | | | | | |
| Gravida: | | | Parity: | | | LMP: | | | | | | Gestation age at referral: weeks | | | | |
| EDD by LMP: | | | | | | | | | EDD by scan: | | | | | | | |
| Height: | | | | | Weight: | | | | | | | | BMI: | | | |
| Ethnicity: | | NZ European  Māori  Samoan  Cook Island Māori  Tongan  Niuean  Chinese  Indian  Other such as Dutch, Japanese, Tokelauan  *please state:* | | | | | | | | | | | | | | |
| **PREVIOUS OBSTETRIC HISTORY** | | | | | | | | | | | | | | | | |
| **Date** | **Place** | **Gest.** | | **Spont./ Induced** | **Labour duration** | | **Type of birth** | | | **Birth weight** | | **A/SB** | | **Gender** | | **Comments** |
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| **FURTHER INFORMATION / COMMENTS / CLINICAL CONCERNS** | | | | | | | | | | | | | | | | |
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**FAX FORM TO: external (03) 364 4301 internal 85301**

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Maternity Booking form details entered into Caresys