**Obstetric Clinic Referral**

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| Maternity Booking Form – if this has already been sent to CWH tick here  Relevant results to referral:  Scans (**Longhurst**)  GROW  Other |

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| **REASON FOR REFERRAL (please provide additional details in Further Information/Comments section)** | | |
| **ANTENATAL** | **POSTNATAL** | **MEDICAL HISTORY** |
| Pregnancy Induced Hypertension (PIH)  Intrauterine Growth Retardation (IUGR)  Oligo/Poly Hydramnios  Previous Caesarean Section  Multiple Pregnancy  Malpresentation  Ante-Partum Haemorrhage (APH)  Recurrent Miscarriage (history of)  Other | **If fetal loss**, please fill in  ‘Postnatal Follow-Up After Fetal Loss’ (Ref.239835) | Endocrine/Diabetes  Cardiac  Haematology  Neurology  Respiratory  Renal  Autoimmune/Rheumatology  Other: |
| Referral Guidelines Section 88:  Primary care  Consultation  Transfer of care |
| **FURTHER INFORMATION/COMMENTS** | | |
|  | | |
| **LMC/REFERRER DETAILS** | | |
| **Name:**  **Address:**  **Telephone:** Home: (……) Mobile:  **Fax:** **Signature**: **Date**: ………/………/……… | | |

DEPARTMENT USE ONLY – TRIAGE INFORMATION

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| **Team to be seen by**: OG1 OG2 OG3 OG4  Consultant/Registrar/Physician name:  Timeframe for appointment: ………../7 ………../52 ………../12 |

**FAX FORM TO: external (03) 364 4301 internal 85301**

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