**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/RheumatologyOther:    |
| 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 OG4Consultant/Registrar/Physician name: Timeframe for appointment: ………../7 ………../52 ………../12 |

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

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