

# Obstetric • Neonatal Referral

Complete form and fax to 8372 4888 Phone 1300 550 654

Please complete patients details or affix label here

Title  Mrs  Ms  Mst  Miss  Other  
 UR \_\_\_\_\_  
 Surname \_\_\_\_\_  
 Given Name \_\_\_\_\_  
 Street \_\_\_\_\_  
 Suburb \_\_\_\_\_ Postcode \_\_\_\_\_  
not below this line

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
 Phone \_\_\_\_\_ Mobile \_\_\_\_\_  
 Alternative discharge address (if different to above) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Nationality \_\_\_\_\_  ATSI  CALD  
 Australian resident  Yes  No  
 Language spoken \_\_\_\_\_ Interpreter Req'd  Yes  No

**Patient lives**  Alone  With partner  Other >  
 Home (rent or owned)  Housing Trust

**Next of kin/carer**  
 Relationship to Patient \_\_\_\_\_  
 Surname \_\_\_\_\_ Given Name \_\_\_\_\_  
 Phone \_\_\_\_\_ Mobile \_\_\_\_\_

**Mother**  
 Gravida \_\_\_\_\_ Para \_\_\_\_\_ Blood Group \_\_\_\_\_ Hb \_\_\_\_\_  
 Type of Delivery > \_\_\_\_\_ Date \_\_\_\_\_  
 Analgesia  Anaesthetic  
 Placenta > \_\_\_\_\_ Membranes > \_\_\_\_\_  
 Perineum > \_\_\_\_\_ Est. Blood Loss > \_\_\_\_\_  
 Wound \_\_\_\_\_  
 Abdominal Suture for removal > Yes No Date > \_\_\_\_\_  
 Antenatal / Medical Hx \_\_\_\_\_

**Diagnosis** Primary > eg: pre-eclampsia, diabetes, methadone program, PND, PPH

Mother \_\_\_\_\_  
 Neonate \_\_\_\_\_  
 Secondary > eg: pre-eclampsia, diabetes, methadone program, PND, PPH \_\_\_\_\_  
 \_\_\_\_\_

**Feeding** >  B/F  A/F Comments > \_\_\_\_\_

**Specific Care Request** > eg: Post Natal Checks Mother & Baby, NNST, Weight Checks \_\_\_\_\_ Mental Health  complete page 2

**Known hazards** (dogs, infections, behavioural, domestic violence) > \_\_\_\_\_

**Current medications** > \_\_\_\_\_

**Medication Authority** attached (if MHL administering) **Allergies** > \_\_\_\_\_

**Other Referred Services** >  CYFH  Dom Midwife  Social Work  Other (specify) > \_\_\_\_\_

**Existing Services** > (specify) \_\_\_\_\_

**Referral Date** > \_\_\_\_\_

**Commencement Date MHL** > \_\_\_\_\_

**Referral Source**

Hospital (specify) > \_\_\_\_\_ DRG > \_\_\_\_\_

Inpatient ward / unit > \_\_\_\_\_

Date: Admission > / / Discharge > / /

QAS

Other (specify) > \_\_\_\_\_

**Referring Doctor** > \_\_\_\_\_

Phone \_\_\_\_\_

**General Practitioner** > \_\_\_\_\_

Phone \_\_\_\_\_

**Specialist** > \_\_\_\_\_

Phone \_\_\_\_\_

**Funding**

Medicare No. \_\_\_\_\_

Pension  Disability \_\_\_\_\_ No. \_\_\_\_\_

DVA (gold card) \_\_\_\_\_ No. \_\_\_\_\_

Health Insurance > \_\_\_\_\_ No. \_\_\_\_\_

**Neonate** >  D/C with Mother  NNU Inpatient

Date of Birth / / Time \_\_\_\_\_ Gest /40

Male  Female \_\_\_\_\_ Post Natal Day

Apgars \_\_\_\_\_

Birth Weight \_\_\_\_\_ gms Discharge Weight \_\_\_\_\_ gms

Vit K  Yes  No  Oral  IM

Phototherapy >  Yes  No SBR \_\_\_\_\_ Date / /

Hearing Test >  Yes  No  N/A Passed >  Yes  No

Neonatal Screening Done >  Yes  No Due / /

Hep B Vac >  Yes  Declined

**Referrer's name** (please print clearly) \_\_\_\_\_

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

**Signature** \_\_\_\_\_

**Phone** \_\_\_\_\_

**Date** \_\_\_\_\_

**Receipt of Referral** \_\_\_\_\_

**Fax No.** \_\_\_\_\_

**Ph No.** \_\_\_\_\_