Osborne Park Hospital
REFERRAL TO ANTENATAL CLINIC

Osborne Place Stirling WA 6021 Tel: (08) 9346 8010 Fax: (08) 9346 8215

(PLEASE PRINT CLEARLY)

PATIENT DETAILS

SURNAME (MS / MISS / MRS)……………………………………………………………………………………..….

MAIDEN NAME / FORMER SURNAMES……………………………………………………………………………….
(Please complete, this information is important)

GIVEN NAMES ……………………………………………………………………………………………………

DATE OF BIRTH………………………………MEDICARE No…………………………………………………….

ADDRESS……

HAS THE PATIENT PREVIOUSLY ATTENDED THIS HOSPITAL ? NO / YES YEAR ……………………

IS AN INTERPRETER REQUIRED? NO / YES Language…………………………………………………

CLINICAL DETAILS ***(to be completed by GP)***

LMP…………...…….EST DATE OF CONFINEMENT……………………GRAVIDA……….. PARA…………

PLEASE FORWARD A COPY OF LABORATORY REPORTS.

BLOOD GROUP	HBsAg	MSU
ANTIBODIES SCREEN	HEPATITIS C	PAP SMEAR (<2yrs)
FBC	HIV	VDRL
RUBELLA	1st TRIMESTER SCREENING (11-13wks)	

ULTRASOUND RESULT (if applicable) BSL (if risk of Gestational diabetes)

SIGNIFICANT HISTORY
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ANTENATAL MANAGEMENT ***(please TICK ONE CARE OPTION below)***

1 Please undertake delivery of this patient. However, following the initial visit to the Antenatal Clinic, I wish to carry out the antenatal care myself until 36 weeks of pregnancy (**Shared-Care**) ☐

2 Following the initial visit to Antenatal Clinic, I wish to perform antenatal care and delivery myself and will refer the Patient back to the Antenatal Clinic for review at 36 weeks ☐

3 Please take this patient for Antenatal Clinic management and delivery ☐

GP NAME (OR STAMP)……………………………………………………………………………………..
ADDRESS ……………………………………………………………………………………………………
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POSTCODE ………… TELEPHONE……………………………FAX……………………………………..

IF YOU WISH TO PROVIDE ANY FURTHER INFORMATION PLEASE APPEND TO THIS REFERRAL