PREGNANCY CARE SERVICE

Coffs Harbour Health Campus
Ph: 6656 5300 Fax: 6656 5118

Health
Mid North Coast
Local Health District

GP REFERRAL FORM

GP Name:
…….……..
Medical Centre: _……
Phone Number: ……
Signature: ……
Date: ……/……/……

Women with a complicated medical/health history may be considered a high risk pregnancy. Consider discussing with the Pregnancy Care Service Coordinator prior to referring the woman.
The triage category for this woman is:
Category 1- 1-2 weeks
Category 2- 2-4 weeks
Category 3- 4-6 weeks

MEDICAL HISTORY:

Cardiac: No Yes:
_____

Respiratory: No Yes:
_____

Renal: No Yes:
_____

G.I.T: No Yes:
_____

Haematology: No Yes:
_____

Autoimmune: No Yes:
_____

Endocrine: No Yes:
_____

Musculoskeletal: No Yes:
_____

Psychosocial: No Yes:
_____

Other:_____

FAMILY HISTORY:

Cardiac: No Yes: _____
Diabetes: No Yes: _____
Hypertension: No Yes: _____
Mental Health: No Yes: _____
Congenital Abnormalities: No Yes: _____
_____

Genetic Counselling:

No :_____Yes:_____

Interpreter needed? No Yes Language: _____

NAME: _____ Age: _____
EXAMINATION: (Preferrably performed by GP before 20 weeks)
Height: _____cm Pre-Pregnancy Weight: _____ kg
Thyroid:_____ Heart Rate:_____ Heart Sounds: _____ Chest: _____ Breasts:_____ Abdomen: _____ Back/Spine: _____ Varicosities:_____ Dental: _____
Breast Examination: _____ Date: _____
Date of Last Pap Smear: _____ Result: _____
Other Findings: _____
_____

Medications:

Substance Use:

Allergies:

Menstrual Cycle: Conception Method: _____

LMP: _____ Days in Cycle: _____ Regular Irregular Unknown

EDB: _____ by LMP or Ultrasound at _____ week's gestation.

The woman is responsible for bringing her own results and reports to the first antenatal appointment in PCS. Please tick the tests performed

Blood Group and Antibody Screen	☐
Full Blood Count	☐
Rubella IgG	☐
Syphilis	☐
Hepatitis B (surface antigen)	☐
Varicella	☐
MSU:	☐

<u>Optional Tests:</u>

Vitamin D (25-OHD	
HIV/Hep C (offered with counselling)	☐
Chlamydia PCR/MSU	☐
Dating Ultrasound (10-13wks)	☐
Nuchal Translucency (11-13.6wks)	☐
Morphology Ultrasound (18-20 wks)	☐

Pathology Collected at:
Sullivan and Nicholaides Laverty Other: _____
Radiology Performed at:
Beachside Coffs Harbour Radiology Other:

COMMUNITY SERVICES: Aboriginal Health Adolescent Health Mental Health Drug & Alcohol Other:

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NSW GOVERNMENT Health Mid North Coast Local Health District

Woman's Booking Form (to be completed by PATIENT)

Ms. Mrs. Miss **SURNAME:** First Name(s): Maiden Name:	MRN (office use) Religion: Aboriginal/T.S.Islander (please circle) Country of Birth: Language spoken at home: Do you require an interpreter? Yes No (Please circle)
Expected Due Date: Date of Birth: Age: Occupation: Family GP:	Home Address:
Your Contact Number: Home:……. Work:……. Mobile:…….	Postal Address: (if different to above)
Mode of Care (Please Circle) For the Antenatal Care, will you be seeing: • Pregnancy Care Service • Private Obstetrician/Doctor If so, Dr …….	Next of Kin: Relationship to Patient: Name: Home …….. Work …….. Mobile ……..
Have you been a patient in this hospital before? (please circle) YES NO	Emergency Contact: Relationship to Patient: Name: Contact Number:……..
Medicare Number: (Including Position on card) __ __ __ __ __ __ __ __ __ __ __ __ Expiry Date:……..	
Private Insurance: YES NO Do you wish to use your Private Insurance? YES NO Fund Name: Membership Number:…….	