Queensland Government

Central Queensland Hospital and Health Service

Maternity Booking in Referral

Facility / Unit: .....

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Phone:

Date of birth: Sex: ☐ M ☐ F ☐ I

Patient Details

Family Name:		Given Names:
Date of birth:	Home Phone:	Work Phone:
Address:		
Next of kin name:		Phone:
Interpreter required? ☐ Yes ☐ No		Language:
Is the woman of Aboriginal or Torres Strait Islander Origin? (both 'yes' boxes may be ticked) ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ No		Is the baby of Aboriginal or Torres Strait Islander Origin? (both 'yes' boxes may be ticked) ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ No

Referral to

To:	Service:	Fax:

Referring Clinician's Details

From:	Phone:	Fax:
Address:		
Provider Number:	Email:	

Clinical Details

Date of first ANTENATAL visit:	GP willing to provide shared care: ☐ Yes ☐ No		
LNMP: Certain? ☐ Yes ☐ No	EDD:	Last pap smear:	BMI:
Dating Scan (if required):		Discussed? ☐ Yes ☐ No Ordered? ☐ Yes ☐ No	
Nuchal translucency plus first trimester serum screen (11-13 weeks +6days):		Discussed? ☐ Yes ☐ No Ordered? ☐ Yes ☐ No	
☐ Chorionic Villus Sampling (CVS) *or* ☐ Amniocentesis:		Discussed? ☐ Yes ☐ No Ordered? ☐ Yes ☐ No	
Morphology diagnostic ultrasound (18 - 20weeks):		Discussed? ☐ Yes ☐ No Ordered? ☐ Yes ☐ No	
Routine antenatal tests ordered at: (please send copies with referral) ☐ S & N ☐ QML ☐ Other:			
Significant obstetric history: Gravida: Para: M/C: Ectopic: TOP:			

Significant medical/surgical history:			
Medication list:			
Allergies:			
Smoking status: cigs/day		Alcohol: drinks/day	
Warnings and alerts:			
Other comments: (e.g. social concerns)			
Referring Clinician's signature:		Date:	

Clear Form **Print**

V0.1-09/2017

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MATERNITY BOOKING IN REFERRAL