



**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? <input type="checkbox"/> Yes <input type="checkbox"/> No		Language:	
Is the woman of Aboriginal or Torres Strait Islander Origin? (both 'yes' boxes may be ticked)		Is the baby of Aboriginal or Torres Strait Islander Origin? (both 'yes' boxes may be ticked)	
<input type="checkbox"/> Yes, Aboriginal <input type="checkbox"/> Yes, Torres Strait Islander <input type="checkbox"/> No		<input type="checkbox"/> Yes, Aboriginal <input type="checkbox"/> Yes, Torres Strait Islander <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No		
LNMP: Certain? <input type="checkbox"/> Yes <input type="checkbox"/> No	EDD:	Last pap smear:	BMI:
Dating Scan (if required):	Discussed? <input type="checkbox"/> Yes <input type="checkbox"/> No Ordered? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Nuchal translucency plus first trimester serum screen (11-13 weeks +6days):	Discussed? <input type="checkbox"/> Yes <input type="checkbox"/> No Ordered? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Chorionic Villus Sampling (CVS) or <input type="checkbox"/> Amniocentesis:	Discussed? <input type="checkbox"/> Yes <input type="checkbox"/> No Ordered? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Morphology diagnostic ultrasound (18 - 20weeks):	Discussed? <input type="checkbox"/> Yes <input type="checkbox"/> No Ordered? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Routine antenatal tests ordered at: (please send copies with referral) <input type="checkbox"/> S & N <input type="checkbox"/> QML <input type="checkbox"/> 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:

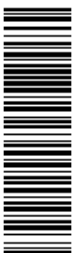
TRIAL

DO NOT WRITE IN THIS BINDING MARGIN

Do not reproduce by photocopying
All clinical forms creation and amendments must be conducted through Health Information Unit

V0.1-09/2017

00141:CQ473



MATERNITY BOOKING IN REFERRAL