Central Gippsland Health
Maternity Referral Form

Date:

Pregnancy Care Clinic

Dear Dr,

Name:_____

Address:_____

_____

Date of Birth: _____

Preferred Contract No: _____

Medicare No.:_____

Medicare expiry date:_____

Gravida:	Para:
LNMP:	EDD:
Height:	Weight:
BMI:	

Referring Doctor
Name:

Signature:

Provider number:

Medical History	
Difficult Airway	
Pre-existing Diabetes	
Moderate to severe Cardiac Disease	
Current or previous Drug Addiction history	
Asthma (hospitalised in last 12 months)	
Haematological disorders such as anaemia, clotting disorders.	
Epilepsy (controlled/uncontrolled)	
Hypertension	
History of multiple pregnancies	
28 weeks with no antenatal care	
Thyroid disorder (controlled/uncontrolled)	
Previous Pregnancies	
3 or more pregnancies	
Seizures in pregnancy or labour	
Rhesus isoimmunisation	
Severe pre-eclampsia	
Other significant maternity problems	
Shoulder dystocia	
Large baby > 4500g	
Small baby < 2500g	
Significant PPH ≥ 1000mLs	
caesarean birth > 1	
The following tests have been requested	
Blood Gp & Antibodies	
FBE	
Hb electrophoresis	
Ferritin	
MSU - m/c/s	
HepBsAg	
Chlamydia	
Dating ultrasound	
TPHA	
Morphology ultrasound	
Aneuploidy screening	
Pap test	
OGTT (if risk factors e.g.: GDM)	
HIV ab	
Rubella IgG	
Random serum glucose	

Medications: