Peninsula Health

REFERRAL
FETAL MONITORING SERVICE

UR NUMBER .....

SURNAME .....

GIVEN NAMES .....

DATE OF BIRTH ..... Gender .....
Please fill in if no Patient Label available

App.18/5/2021 Print Code:18006

PHF3527643

Referral to: ***Dr Jolyon Ford***

Fetal Monitoring Service
Women's Services Antenatal Clinic
Outpatient Area 1, Building D
Frankston Hospital
Phone: 9784 2600
Fax: 9788 1880

Referring Doctor (Stamp):

Contact number of doctor:

Provider number:

Language spoken at home ..... Interpreter required ☐ Yes ☐ No

Telephone number ..... Gestation at referral .....

Pregnancy LMP ...../...../..... EBD ...../...../..... Gravidity ..... Parity ..... BMI .....

Clinical indication / provisional diagnosis

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☐ Gestation ≥ T+10
☐ Diabetes GDM /T1/ T2/medication (circle)
☐ Preeclampsia
☐ Gestational hypertension
☐ Decreased fetal movements
☐ EFW / AC<10th centile
☐ PPROM
☐ Oligohydramnios
☐ Abnormal dopplers
☐ Other .....
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Past obstetric history

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Medical history / current medication / allergies

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Examination requested

☐ Growth and Wellbeing scan (Fetal biometry, AFI and Umbilical artery and MCA Dopplers)
☐ Wellbeing scan (AFI and Umbilical artery and MCA Dopplers)
☐ AFI ☐ MCA PSV ☐ CTG ☐ Uterine artery doppler
☐ Other (please describe) .....

Plan for follow up

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MR/352764

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