Peninsula Health
Women's Services

REFERRAL
FETAL DIAGNOSTIC SERVICE

UR NUMBER .....

SURNAME .....

GIVEN NAMES .....

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

App.15/1/18 Print Code:17433

PHF352760v

Referral Date: ...../...../.....

Referral to: *Dr. Jolyon Ford*

Fetal Diagnostic Service
Women's Services Antenatal Clinic
Outpatient Area 1 Building D
Frankston Hospital

Phone: 9784 2600
Fax: 9788 1879
If Urgent Ring: 9784 2647

Referring Doctor:

Provider Number .....
Signature:

This patient is being referred for: Fetal diagnostic ultrasound / Invasive testing (CVS/Amniocentesis) delete as appropriate

Title: ..... Given Name: ..... Surname: .....

Contact Phone Number: ..... Partner's Name: .....

Patient Address: .....

Date of Birth: ...../...../..... Medicare Card Number: .....

Spoken Language: ..... Interpreter Required: ☐ Yes ☐ No

Pregnancy: LMP: ...../...../..... EDD: ...../...../..... Gravidity ..... Parity ..... BMI .....

Indication: Abnormal screening test / High risk of genetic anomaly (eg FH, previous affected baby)
Abnormal ultrasound finding / Maternal infection / PI accreta / Vasa Praevia / Severe IUGR/MCDA Twins

Details: .....

.....

Past Obstetric History: .....

.....

Family History: .....

.....

Medical History / Drugs / Allergies: .....

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What counselling has been provided:

☐ Verbal ☐ Written Information ☐ Referred to Monash Genetics Services

GP Name & Practice Address (if not referred by GP)

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Ensure that the following are included in the referral:

- ☐ ultrasound reports
- ☐ antenatal screening test results
- ☐ blood group and antibody result

Office Use Only

Received: ...../...../.....

Triaged: ...../...../.....

Outcome: Accept / Reject
More information required

Ultrasound
Booked : ...../...../.....

ANC
Booked : ...../...../.....

Pt & Dr Notified: Phone / Mail

Date Notified: ...../...../.....

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MR/352760