AUCKLAND DISTRICT HEALTH BOARD
Te Toka Tumai

SURNAME: _____ NHI: _____

FIRST NAMES: _____

DATE OF BIRTH: ____/____/____ SEX:

Please attach patient label here

National Women's Fetal Medicine Service Referral

Date of Referral _____

Name of Referrer and Address	**Contact Details**
Patient Name and NHI	**Address and Contact details**
Date of Birth	**Telephone** **Home** **Mobile**
LMC Name **Address** **Phone**	**GP Name** **Address** **Phone**
LMP **EDD (USS confirmed)** **Gravidity Parity**	**Date of last scan** **Scan report enclosed: Yes ☐ No ☐**
Nuchal translucency scan performed **Yes ☐ No ☐**	**Result of NT scan**
Blood group	**Antenatal screening results enclosed?** **Yes ☐ No ☐**
Reason for referral / provisional diagnosis	**Referral discussed with** **At National Women's Fetal Medicine Service** **Date**
All scan reports attached? **Yes ☐ No ☐**	**First Antenatal Blood results attached?** **Yes ☐ No ☐**
Has appointment been made already? **Yes ☐ No ☐**	**Appointment** **Date Time**

Please complete all the details so Fetal Medicine Team can process the referrals as soon as possible.
Fax: 09 375 7080.
For urgent referrals phone: 09 307 4949 ext 24951.

FETAL MEDICINE SERVICE REFERRAL

CR2943