REFERRAL FORM

Patient information

Name ____ NHI_______________________

DOB (dd/mm/yy) ________________ Needs interpreter? If yes, language __________________

Postal address ____

Best phone number to reach her or leave a confidential voicemail __________________________

Note: Please refer to general ANC if after 2 previous CS an ELRCS is wanted OR if there has been a previous successful VBAC.

Tick one: --- Postnatal review of caesarean birth and options for next pregnancy and birth
--- Antenatal discussion of options for current pregnancy and birth

Tick one: --- One previous CS wanting to discuss VBAC versus Elective Repeat CS
---Two or more previous CS wanting to discuss VBAC

Clinical information (**NOTE: it is important that all questions in the box are completed OR attach brown card (both pages) and GROW chart**)

Maternal age __________ G ___ P ___ Booking weight _____kg Height ____cm
Ethnicity _____________________________

Date of previous caesarean (dd/mm/yy) ___________ Where________________________
Reason ____

Baby weight _________________ Baby sex M F

Date of LMP (dd/mm/yy) _____________ uncertain unknown

Date of EDD (dd/mm/yy) based on LMP

Clinical or other concerns, or specific questions

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Date of Referral (dd/mm/yy) ______________ Gestational age at time of referral _______ weeks

Your information as LMC Name________________________________Fax number_______________

If birth was outside ADHB, please try to include the operative note and labour and birth summary.

PLEASE FAX THIS FORM TO THE WALK-IN CENTRE; Fax 09 6309781

Sept 2015