AUCKLAND DISTRICT HEALTH BOARD
Te Toka Tumai

SURNAME: _____ NHI: _____

FIRST NAMES: _____

DATE OF BIRTH: ____/____/____ SEX:

Please attach patient label here

National Women's
Maternal 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**	**Antenatal screening results enclosed?** **Yes** ☐ **No** ☐
Blood group	**First Antenatal Blood results enclosed?** **Yes** ☐ **No** ☐
All scan reports attached **Yes** ☐ **No** ☐	
Reason for referral / provisional diagnosis	**Referral discussed with** **At National Women's Fetal Medicine Service** **Date**
Relevant Obstetric History	**Relevant Medical History**
Has appointment been made already? **Yes** ☐ **No** ☐	**Appointment** **Date** **Time**

Please complete all the details so Maternal Medicine Team can process the referrals as soon as possible.
Fax: 09 375 7080.
For urgent referrals phone: 09 307 4949 ext 25357.

MATERNAL MEDICINE SERVICE REFERRAL

CR2944