AUCKLAND
DISTRICT HEALTH BOARD
Te Toka Tumai

National Women's Fetal Medicine Service Referral

MUST ATTACH PATIENT LABEL HERE

SURNAME: _____ NHI: _____

FIRST NAMES: _____ DOB: _____

Please ensure you attach the correct visit patient label

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 Email 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 ☐	**Interpreter Required?** Yes ☐ No ☐ Language:
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: 09 307 2894. Email: FetalMedicineScheduling@adhb.govt.nz
For urgent referrals phone: 09 307 4949 ext 24951.

FETAL MEDICINE SERVICE REFERRAL

CR2943