AUCKLAND DISTRICT HEALTH BOARD
Te Toka Tumai

National Women's Health Day Assessment Unit Referral

SURNAME: _____ **NHI:** _____

FIRST NAMES: _____

DATE OF BIRTH: ____/____/____ **SEX:** _____

Please attach patient label here

Referral to be completed, faxed and appointment made prior to admission to DAU

Appointment made: _____ Date: _____ Time: _____

Date referral sent:	Woman under care of: –
	EDD: – G P
	Next Clinic Appointment: –

Reason for Referral:

- ☐ GPH
- ☐ IUGR
- ☐ Postdates surveillance
- ☐ Liquor anomalies (PPROM, Poly)
- ☐ ECV
- ☐ Twins
- ☐ Cholestasis in Pregnancy
- ☐ Iron Transfusion
- ☐ Other (please specify) _____

Any other relevant medical conditions/risk factors:

_____

_____

_____

_____

Management Plan:

- ☐ CTG how often _____
- ☐ Scan
- ☐ Dopplers how often? _____
- ☐ Growth
- ☐ Liquor volume
- ☐ Bloods
- ☐ GPH Assessment
- ☐ Other Investigations

Name of referring clinician _____

Locator No.: _____ Cellphone: _____

It is important to be able to contact you regarding findings and further care planning

Relevant History & Factors

_____

_____

_____

_____

_____

_____

DAY ASSESSMENT UNIT REFERRAL

CR8791

Telephone: 307 4949 ext. 25907

Fax to DAU: 307 8904 int. 25905