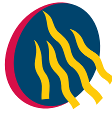

Southside Health Service District (Bayside)
Queensland Government
Queensland Health

GENERAL PRACTITIONER
REFERRAL FORM

REDLAND HOSPITAL

ANTENATAL CLINIC

Phone: 3488 3435 Fax: 3488 3436

Please affix Patient ID label here

Surname: ______________________________

Given Names: ______________________________

DOB: ______________ Ph: ________________

Address: ______________________________

____

GENERAL PRACTITIONER DETAILS

Name of Practice: ______________________

Treating Doctor: ______________________ Address: ______________________________

____________________________________ Ph: __________________ Fax: ____________

APPOINTMENT

Urgent ☐ Non Urgent ☐ Will accept Share Care Yes/No

Interpreter Required Yes/No If yes, please specify language: __________________

MANDATORY FIELDS

Last Menstrual Period __/__/____ Expected date of Confinement __/__/____

Gravida: _____ Parity _____ Medications: ________________________________

____

Past Obstetric & Medical History: ____

____

____

____

ANTENATAL INVESTIGATIONS

Nuchal Translucency Scan (11 – 13.6 weeks) ☐ PAPP – A ☐

Referral for Morphology Scan (18 – 20 weeks) ☐ WEIGHT _________

BLOOD TESTS

Sent to Antenatal Clinic ☐

Given to the Patient ☐

Laboratory: S & N / QML / Mater Pathology

FBC ☐

Blood Group & Antibodies ☐

Rubella Serology ☐

Hepatitis B & C ☐

Syphilis ☐

HIV ☐

General Practitioner Signature: Date:

GENERAL PRACTITIONER REFERRAL FORM