



Queensland Government

Maternity Booking In Referral

Hospital use only
Attach label or enter URN:

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Please complete patient contact details in full — to allow us to contact your patient promptly

Patient details

Family name:		Given names:	
Date of birth: / /	Home phone:	Work phone:	
Address:			
Next of kin name:			Phone:
Interpreter required? <input type="checkbox"/> Yes <input type="checkbox"/> No		Language:	
Indigenous status: <input type="checkbox"/> Aboriginal but not Torres Strait Islander origin		<input type="checkbox"/> Neither Aboriginal or Torres Strait Islander origin	
<input type="checkbox"/> Torres Strait Islander but not Aboriginal origin		<input type="checkbox"/> Not stated / unknown	
<input type="checkbox"/> Both Aboriginal and Torres Strait Islander origin			

Referral to

To: Dr	Service:	Fax:
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Referring doctor details

From: Dr	Phone:	Fax:
Address:		
Provider number:	Email:	

Clinical details

LNMP: / / Certain? <input type="checkbox"/> Yes <input type="checkbox"/> No	EDD: / /	Last pap smear: / /
Nuchal translucency <i>plus</i> first trimester serum screen (11–13 weeks + 6 days):		Discussed? <input type="checkbox"/> Yes <input type="checkbox"/> No
		Ordered? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Chorionic Villus Sampling (CVS) OR <input type="checkbox"/> Amniocentesis		Discussed? <input type="checkbox"/> Yes <input type="checkbox"/> No
		Ordered? <input type="checkbox"/> Yes <input type="checkbox"/> No
Morphology diagnostic ultrasound (18–20 weeks):		Discussed? <input type="checkbox"/> Yes <input type="checkbox"/> No
		Ordered? <input type="checkbox"/> Yes <input type="checkbox"/> No
Routine antenatal tests orders at: (<i>please send copies with referral</i>) <input type="checkbox"/> S&N <input type="checkbox"/> QML <input type="checkbox"/> Other:		
Significant obstetric history:	Gravida:	Para:
	M/C:	Ectopic:
		TOP:
Significant medical / surgical history:		
Medication list:		
Allergies:		
Other comments: (<i>eg. social concerns</i>)		

Referring doctor's signature:	Date: / /
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DO NOT WRITE IN THIS BINDING MARGIN

MATERNITY BOOKING IN REFERRAL