REQUEST FOR OUTPATIENT APPOINTMENT
OBSTETRICS ANTENATAL
Fiona Stanley Hospital

SHARE CARE ☐ **Yes** _____ ☐ **No** _____
PLEASE NOTE ALL GP'S WISHING TO ENTER A SHARE CARE PARTNERSHIP WITH FSH MUST USE THE NWHPR AND FOLLOW THE FSH GP SHARED CARE GUIDELINES 2016.

Please print in UPPERCASE and ensure all fields are completed prior to faxing.

Patient Details

Family Name _____
Given Name _____
Date of Birth _____
Address _____
_____
Home Contact _____
Mobile Contact _____
Maiden Name _____
Previous Family Name _____
Have you been hospitalised in the last 7 Days?
☐ **Yes** _____ ☐ **No**
Admission Date _____ **Discharge Date**
Medicare Number _____
Ref No _____ **Expiry Date**

NOK Relationship _____
NOK Family Name _____
NOK Given Name _____
NOK Address _____
NOK Contact _____
Have you previously been to Fiona Stanley Hospital?
☐ Yes ☐ No
Marital Status _____
Interpreter: ☐ No ☐ Yes
Employment Status
Health Care Card / Pension
Ref No _____ **Expiry Date**

Remember: Patients must bring their Medicare Card to their appointments

GP Referral Details

Referring GP _____
Surgery _____
Address _____
Phone _____

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Patient Details

Gravida _____ **Para** _____ **LMP** _____

EDD (by dates) _____ **EDD (by Ultrasound)** _____

Weight _____**kgs** **Height** _____**m** **BMI** _____

Current Pregnancy:	**Previous Obstetric History/Complications:**
Allergies:	**Significant Medical History:**

To ensure all women have the required Antenatal investigations we request you to order the following tests and ensure photocopies of results from the tests listed below are sent to Fiona Stanley Hospital and/or give to the patient to bring to their first Antenatal Clinic Appointment.

☐Results Attached ☐Results with Patient ☐Results sent direct to FSH Fax

Check (X) beside those test you have the results for or if you have arranged the test.
PathWest collection centre is available at Fiona Stanley and results for tests performed at PathWest are automatically made available to staff at Fiona Stanley.
**Please attend GTT early if previous history of GDM

Full Blood Picture including Fe	☐	Glucose Tolerance Test **	☐
Group and atypical antibodies	☐	Midstream Sterile Urine	☐
Hep B Surface antigen / Hep C	☐	Pap (within 2 years)	☐
HIV antibodies	☐	Early dating ultrasound (if dates	☐
Rubella antibodies	☐	1st trimester screen (11-13wks)	☐
Syphilis antibodies	☐	Fetal anatomy U/S 18 to 20 wks	☐
Chlamydia	☐	Iron Studies	☐
TFT	☐	Vitamin D	☐
Other	☐		

Please send this completed form to: **Fiona Stanley Referral Service** **FAX 6152 9762**
(One patient per