

**MATERNITY REFERRAL**

**Phone: 8372 4999 Fax: 8372 4900**

Title: ..... Client Surname: ..... Given Name: .....

Address: .....

Postcode: ..... D.O.B: ..... Ph: ..... Mob: .....

Postal Address: (If different from above).....

Country of Birth: ..... Medicare Number: .....

N.O.K: ..... Relationship: ..... Ph: .....

**FUNDING:**  Health Fund: ..... Membership Number: .....

Self Funded  Other:.....

**REFERRING - OBSTETRICIAN / PAEDIATRICIAN / GP:**.....

Provider Number: ..... Ph: ..... Fax: .....

Referring Hospital: ..... Admission Date: ..... Discharge Date: .....

Hospital UR No: ..... Ph:..... Fax: .....

Self Referral: .....  Other: .....

**DIAGNOSIS:**

Primary: .....

Secondary:.....

A/N History: .....

Delivery Type:  Normal Vaginal  Instrumental  Ventouse  Breech  Episiotomy  LSCS Gestation:.....wks

Delivery date:.....time..... Gravida:....Parity: .... Baby's Gender:  Male  Female Birth wt.....D/C wt.....

**TREATMENT REQUEST:** (tick appropriate boxes)

❖ **Ante Natal**

Monitor vital signs & Ante natal observations  Other: .....

Home care support (domestic / family care) .....

❖ **Post Natal – Maternal**

Monitor Post natal observations & checks  Breast feeding support: .....

Baby care support  Alternate feeding management

Wound management:  Episiotomy  LSCS wound  Removal of suture - date:.....

Home care support (domestic / family care)

❖ **Post Natal – Baby**

Monitor vital signs and neonatal checks  Newborn Screening Test

Feeding management and support  Weight monitoring

❖ **Other** (Specify ) .....

**Other Relevant Information: Allergies /Hazards/Infections:** (Animals, Behavioural. MRSA etc.) .....

**Name of Referrer:** ..... **Referrer's Signature:** ..... **Position:**.....

**Doctor's Signature:** ..... **Provider No:** ..... **Date:** .....