REQUEST FOR CONSULTATION

GOLD COAST HOSPITAL AND HEALTH SERVICE

**MATERNITY SERVICES CLINIC**

Template for correspondence about patient with

**MATERNAL FETAL MEDICINE**

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| **SEND TO** Professor David Ellwood (Director of Maternal Fetal Medicine)PHONE: 07 5687 1149FAX: **07 5687 6799**B Block Level 1, 1 Hospital Boulevard, Southport 4215Email: mfm\_gcuh@health.qld.gov.au | **FROM** **Doctors Name:** **Practice Name:****Practice Address:****Phone:** **Fax:** **Email:** **Provider Number:**  |

**SEND ONLY BY FAX TO 5687 6799**

**DO NOT SEND to OUTPATIENT ACCESS AND SCHEDULING CENTRE**

**SEPARATE REFERRAL FOR ANTENATAL CARE IS REQUIRED TO ANTENATAL CLINIC GCUH**

**GP Liaison Antenatal Services** Mon – Fri 8.00am-4:30pm Phone 07 5687 1525

For urgent pregnancy advice after hours please contact the **Maternity Assessment Clinic**: 07 5687 1424

Early Pregnancy Assessment Service (less than 16 weeks gestation) Phone: 07 5687 5061 Fax: 07 5687 7892

Dear Professor Ellwood

**SECTION 1 Patient details**

**Patient Full Name:**

**DOB:**

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| **Gender:** **Address:** **Home Ph**: **Mobile Ph:** **Medicare Number\*:** (\*Medicare ineligible patients will incur a consultation fee) | **Next of Kin/Alternative Contact:** **Next of Kin/Alternative Contact Ph:** **Does patient identify as Aboriginal and/or Torres Strait** **Islander:** **Interpreter required:** **If yes, specify language:**  |

**SECTION 2 Reason for referral**

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| Main reason for this referral or relevant history, clinical examination findings and treatment to date:**Tertiary Ultrasound Assessment:** **Fetal Growth and Wellbeing:** **Multiple Pregnancy:** **Cervical and Placental Assessment:** **First Trimester Combined Screening (high risk patients only):** **Morphological Assessment in High Risk Pregnancy:** **Consultation for High Risk for CFTS:** **Diagnostic testing of Amniocentesis for CVS (include blood group):** **Paste or type relevant history, clinical examination findings and treatment to date if required** |

**SECTION 3 Mandatory clinical information**

Gravida - total number of pregnancies:

Parity - total number of births:

Last menstrual period:

Miscarriage/TOP:

Current blood pressure:

Patient's BMI:

Estimated date of delivery:

**SECTION 4 Investigations**

**PREVIOUS ULTRASOUND REPORTS ARE REQUIRED WITH THIS REFERRAL**

**Ultrasound scans:**

**SECTION 5 Social factors and impact on the patient**

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| Consider the impact on employment/education; activities of daily life; ability to care for others; personal safety/frailty;other factors. **Please paste or type relevant information.** |

**SECTION 6 Medical history including co-morbidities and previous surgical interventions**

**Alcohol Status/History:**

**Smoking Status/History:**

**Medical History:**

**Comorbidities:**

**Previous Procedures:**

**Allergies/Adverse Reactions:**

**Current prescribed medications:**

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| **SMOs/VMOs in this Specialist Service** |

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| Professor David Elwood (Director of MFM) | Dr Adriana Olog  |  Dr Justin Nasser  |