Please use ID label or block print

ARMADALE HEALTH SERVICE

REFERRAL FOR ANTENATAL CARE AND DELIVERY

Family Name | UMRN:

Given Names: | DOB:

Fill in electronically and email to **ArmadaleANC@health.wa.gov.au** or print and mail to Armadale Health Service, Antenatal Clinic, PO Box 460, Armadale, WA, 6992 or alternatively fax to **(08) 9391 2293**. Please include all blood and scan results/reports, preferably before 14 weeks gestation so that an 18 week midwife appointment can be allocated.

Referral Date: **Name of Referee:** **Signature:**

Address: **Provider number:**

PREFERRED MODELS OF CARE:

- ☐ GP own and public delivery — Name of GP-Obs:
- ☐ Public ANC from 20 wks and public delivery
- ☐ Midwifery Group Practice - from 12 wks and public delivery
- ☐ Private patient under the care of GP-Obs or eligible midwife — Name of Practitioner:
- ☐ Community Midwifery Program — Name of program: ☐ Home Birth ☐ Domino

PATIENT INFORMATION

Given Name(s):		**Family Name:**	
Previous Name(s): (eg maiden)		**Date of Birth:**	
Address:			
Home Phone:		**Mobile:**	
Country of Birth:		**Ethnicity:**	
Interpreter required:	☐ Yes ☐ No	**Language Spoken:**	
Height (cm):		**Weight (kg):**	
Medicare number:	**Exp:**	**LMP:**	
Gestation at dating scan		**EDD acc to LMP:**	
If twin pregnancy (select type)	Select Type	**EDD acc to Scan:**	
Influenza Vaccination	☐ Yes ☐ No	**Date of vaccination:**	
Known medical conditions:			

PREVIOUS PREGNANCY INFORMATION

Pregnancy	Year	Outcome (select from list)	Name	Gestation (w)	Weight (kg/lb)
1.		Select From List			
2.		Select From List			
3.		Select From List			
4.		Select From List			
5.		Select From List			

ANTENATAL TESTS PERFORMED: (Tick box if done and attach to fax)

REQUIRED ON ALL PATIENTS

- ☐ Dating Scan
- ☐ First trimester screening (11-14w)
- ☐ Details scan (18-22w) if already performed or Date Booked:
- ☐ Full Blood Count
- ☐ Blood Group Antibodies
- ☐ Chlamydia
- ☐ Hepatitis B and C
- ☐ HIV
- ☐ Syphilis
- ☐ Rubella Titre
- ☐ Varicella
- ☐ Midstream urine
- ☐ Vitamin D level

ONLY IF INDICATED

- ☐ Ferritin level
- ☐ Vitamin B12 level
- ☐ Folate Level
- ☐ Thyroid Stimulating Hormone (TSH)
- ☐ Haemoglobinopathy screening
- ☐ Glucose screening (High risk patient)
- ☐ Pap smear
- ☐ Gonorrhoea