Queensland Government

Maternity Booking In Referral

Medicare number: .....
☐ Ineligible *(provide comments in patient details below)*

Hospital use only
Attach label or enter URN:
.....

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

Patient details

Family name:	Given name(s):	
Date of birth: / /	Home phone:	Work phone:
Address:		
Next of kin name:		Phone:
Interpreter required? ☐ Yes ☐ No	Language:	
Is the woman of Aboriginal or Torres Strait Islander origin? *(both 'Yes' boxes may be ticked)* ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ No	Is the baby of Aboriginal or Torres Strait Islander origin? *(both 'Yes' boxes may be ticked)* ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ No	
If ineligible for Medicare, provide comments:		

Referral to

To:	Service:	Fax:
First antenatal appointment with your GP: / /		

Referring doctor / clinician details

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

Clinical details

LNMP: / / Certain? ☐ Yes ☐ No	EDD: / /	Last cervical screening test (CST): / /	BMI:
Reproductive carrier screening undertaken prior to or in early pregnancy:	Discussed? ☐ Yes ☐ No	Ordered? ☐ Yes ☐ No	
Nuchal translucency *plus* first trimester serum screen (11–13 weeks + 6 days):	Discussed? ☐ Yes ☐ No	Ordered? ☐ Yes ☐ No	
NIPT:	Discussed? ☐ Yes ☐ No	Ordered? ☐ Yes ☐ No	
☐ Chorionic Villus Sampling (CVS) *OR* ☐ Amniocentesis	Discussed? ☐ Yes ☐ No	Ordered? ☐ Yes ☐ No	
Morphology diagnostic ultrasound (18–20 weeks):	Discussed? ☐ Yes ☐ No	Ordered? ☐ Yes ☐ No	
Early OGTT/HBA1C indicated (high risk for GDM):	Discussed? ☐ Yes ☐ No	Ordered? ☐ Yes ☐ No	
Routine antenatal tests orders at: *(please send copies with referral)*	☐ S&N ☐ QML ☐ Other:		
I have made a booking to administer dTpa at or after 20 weeks:	☐ Yes ☐ No		
I have administered the influenza vaccine this pregnancy:	☐ Yes ☐ No	Date given: / /	
COVID-19 vaccinations up to date:	☐ Yes ☐ No	Doses completed during pregnancy:	
Significant obstetric history: Gravida: Para: M/C: Ectopic: TOP:			
Discussed models of care options: ☐ Yes ☐ No	Shared Care (GP Agreement): ☐ Yes ☐ No		
Significant medical / surgical history:			
Medication list:			
Allergies:			
Smoking status: cigs / day	Alcohol: drinks / day		
Warnings and alerts:			
Other comments (e.g. social concerns):			

Referring doctor's / clinician's signature:	Date: / /

DO NOT WRITE IN THIS BINDING MARGIN

MATERNITY BOOKING IN REFERRAL

v8.00 - 04/2023

SW071a