

PATIENT DETAILS

***SURNAME:** _____ ***GIVEN NAME:** _____
Previous name: _____ ***D.O.B:** _____ **UR number (if known)** _____
***ADDRESS:** _____
***TELEPHONE: Home:** _____ **WORK/or in hours:** _____
Mobile: _____ **Country of birth:** _____
Interpreter required: N Y **Language:** _____

PREFERRED HOSPITAL: Casey Dandenong MMC Clayton
PREFERRED TYPE OF CARE: *(Note: All hospitals & public clinics have monthly limits on numbers)*
 Hospital clinic Non hospital *(circle) Specialist obstetrician / GP obstetrician / Shared care with obstetrician*
 Shared care with hospital clinic

INITIAL MEDICAL ASSESSMENT

MATERNITY	MEDICAL HISTORY
<p>*Starred items must be completed for booking to proceed</p> <p>Current pregnancy: LNMP _____ *Estimated due date (EDD) _____ * Height ____ *Weight ____ BMI = ____ * Booking > 28 weeks without antenatal care <input type="checkbox"/> No <input type="checkbox"/> Yes * First pregnancy <input type="checkbox"/> N <input type="checkbox"/> Y (if yes complete only medical history) <input type="checkbox"/> Multiple pregnancy (if known)</p> <p>Past maternity history (Please mark any that apply) <input type="checkbox"/> Previous severe pre-eclampsia/fits in pregnancy or labour <input type="checkbox"/> Previous Rhesus isoimmunisation <input type="checkbox"/> Previous caesarean birth 1 only <input type="checkbox"/> more than 1 <input type="checkbox"/> <input type="checkbox"/> Parity > 5 babies <input type="checkbox"/> Miscarriage/mid trimester loss x 3 or more <input type="checkbox"/> Significant PPH ≥ 1000mLs <input type="checkbox"/> Previous small baby <2500 (5lb 8oz) <input type="checkbox"/> Previous large baby > 4500g (9lb 15oz) <input type="checkbox"/> Previous shoulder dystocia</p>	<p style="text-align: center;">Please mark any that apply</p> <p><input type="checkbox"/> Anaesthetic difficulties <input type="checkbox"/> Diabetes before being pregnant <input type="checkbox"/> Cardiac disease - significant _____ <input type="checkbox"/> Asthma (with hospital admissions in last 12 months) <input type="checkbox"/> Illicit drug abuse or methadone/buprenorphine <input type="checkbox"/> Rare or severe medical problems (give details below) <input type="checkbox"/> Hypertension (list any medication below) <input type="checkbox"/> Thyroid disease (uncontrolled) <input type="checkbox"/> Haematological disorders: eg Hb<90g/L or DVT <input type="checkbox"/> Epilepsy on medication <input type="checkbox"/> On medications (list below) <input type="checkbox"/> Allergies _____</p> <p>Additional information:</p>

INVESTIGATIONS CHECKLIST

Please tick ordered tests and give a copy of results to your patient to bring to her first appointment

<u>Recommended</u>	<u>Consider</u>
<input type="checkbox"/> Blood Gp & Antibodies <input type="checkbox"/> HIV serology	<input type="checkbox"/> Dating ultrasound <input type="checkbox"/> Thalassaemia screen
<input type="checkbox"/> Hepatitis B <input type="checkbox"/> FBE <input type="checkbox"/> Vitamin D	<input type="checkbox"/> Hep C <input type="checkbox"/> Pap test
<input type="checkbox"/> Rubella <input type="checkbox"/> MSU/Urinalysis <input type="checkbox"/> Syphilis	<input type="checkbox"/> Ferritin <input type="checkbox"/> Chlamydia
<input type="checkbox"/> Morphology ultrasound (18-20wks)	<input type="checkbox"/> 1 st or 2 nd trimester prenatal aneuploidy screen

REFERRER DETAILS

***Dr (Name)** _____ * GP or Specialist
Practice address _____ * **Provider No.** _____
Phone: _____ **Fax:** _____

Office use only

Hospital _____	Model _____	iPM <input type="checkbox"/>
Clinic code _____	Appointment date ___/___/___	BOS <input type="checkbox"/>
	Time _____	Letter <input type="checkbox"/>