



**Queensland  
Government**

# Maternity Booking In Referral

Hospital use only  
 Attach label or enter URN:

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

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? <input type="checkbox"/> Yes <input type="checkbox"/> No		Language:	
Is the woman of Aboriginal or Torres Strait Islander origin? (both 'yes' boxes may be ticked) <input type="checkbox"/> Yes, Aboriginal <input type="checkbox"/> Yes, Torres Strait Islander <input type="checkbox"/> No		Is the baby of Aboriginal or Torres Strait Islander origin? (both 'yes' boxes may be ticked) <input type="checkbox"/> Yes, Aboriginal <input type="checkbox"/> Yes, Torres Strait Islander <input type="checkbox"/> No	
If ineligible for Medicare, provide comments:			

## Referral to

To:	Service:	Fax:
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## Referring doctor / clinician details

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

## Clinical details

LNMP: / /	Certain? <input type="checkbox"/> Yes <input type="checkbox"/> No	EDD: / /	Last pap smear: / /	BMI:
Nuchal translucency <i>plus</i> first trimester serum screen (11–13 weeks + 6 days): Discussed? <input type="checkbox"/> Yes <input type="checkbox"/> No Ordered? <input type="checkbox"/> Yes <input type="checkbox"/> No				
NIPT: Discussed? <input type="checkbox"/> Yes <input type="checkbox"/> No Ordered? <input type="checkbox"/> Yes <input type="checkbox"/> No				
<input type="checkbox"/> Chorionic Villus Sampling (CVS) OR <input type="checkbox"/> Amniocentesis Discussed? <input type="checkbox"/> Yes <input type="checkbox"/> No Ordered? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Morphology diagnostic ultrasound (18–20 weeks): Discussed? <input type="checkbox"/> Yes <input type="checkbox"/> No Ordered? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Routine antenatal tests orders at: (please send copies with referral) <input type="checkbox"/> S&N <input type="checkbox"/> QML <input type="checkbox"/> Other:				
I have made a booking to administer dTpa at or after 28 weeks: <input type="checkbox"/> Yes <input type="checkbox"/> No		I have administered the influenza vaccine this pregnancy: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Significant obstetric history:	Gravida:	Para:	M/C:	Ectopic: TOP:
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: / /
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DO NOT WRITE IN THIS BINDING MARGIN

MATERNITY BOOKING IN REFERRAL

