AUCKLAND
DISTRICT HEALTH BOARD
Te Toka Tumai

National Women's Maternal Medicine Service Referral

MUST ATTACH PATIENT LABEL HERE

SURNAME: _____ NHI: _____

FIRST NAMES: _____ DOB: _____

Please ensure you attach the correct visit patient label

Date of Referral _____

Name of Referrer and Address	**Contact Details**
Patient Name and NHI	**Address and Contact details**
Date of Birth	**Telephone** Home Mobile
LMC Name **Address** **Phone**	**GP Name** **Address** **Phone**
LMP **EDD (USS confirmed)** **Gravidity** **Parity**	**Antenatal screening results enclosed?** ☐ Yes ☐ No
Blood group	**First Antenatal Blood results enclosed?** ☐ Yes ☐ No
All scan reports attached ☐ Yes ☐ No	
Reason for referral / provisional diagnosis	**Referral discussed with** **At National Women's Fetal Medicine Service** **Date**
Relevant Obstetric History	**Relevant Medical History**
Has appointment been made already? ☐ Yes ☐ No	**Appointment** Date Time

Please complete all the details so Maternal Medicine Team can process the referrals as soon as possible.
highriskservices@adhb.govt.nz
For urgent referrals phone: 09 307 4949 ext 29198.

MATERNAL MEDICINE SERVICE REFERRAL

SINGLE SIDED FORM – Reverse not scanned
DO NOT DOCUMENT CLINICAL NOTES ON BACK

05/21
CR2944