AUCKLAND DISTRICT HEALTH BOARD
Te Toka Tumai

National Women's Health Obstetric Ultrasound Request Form

Patient Name: _____

NHI: _____ **Date of Birth:** _____/_____/_____

Sex: _____

Patient Address: _____

_____

Patient Contact No.: _____

Patient Email: _____

This form is only to be used for referrers who do not have access to e-referrals.
For Greenlane Clincial Centre it should be emailed to the NWHultrasound@adhb.govt.nz
For Auckland City Hospital it should be emailed to NWHACHultrasound@adhb.govt.nz

Requesting Clinician Details			
Requesting Obstetrician/ Midwife Name:		**Contact No.:**	
Medical Council Number:		**Email:**	
Practice Name and Address:			
Request Details			
Mandatory Information	**EDD:** _____		
Supporting Clinical Information:			
Exam Suggested *Please attach previous anatomy report with this request if the scan was not performed at National Women's Health Ultrasound.* **Previous Report attached…..☐**			
Single Pregnancy ☐		**Multiple Pregnancy ☐**	
First Trimester	**Dating……..☐** **Nuchal……..☐**		
Second Trimester	**Anatomy…..……..☐** **Follow Up Anatomy……..…..☐** **Growth……..…..☐**		
Third Trimester	**Growth……..……..☐** **Growth/Doppler……..……..☐**		
Other ☐	*Please state:*		
Additional booking information:			