

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	Date of Last Scan Scan report enclosed: Yes <input type="checkbox"/> No <input type="checkbox"/>
Nuchal Translucency Scan Performed Yes <input type="checkbox"/> No <input type="checkbox"/>	Interpreter Required? Yes <input type="checkbox"/> No <input type="checkbox"/> Language:
Blood Group	Antenatal Screening Results Enclosed? Yes <input type="checkbox"/> No <input type="checkbox"/>
Reason for Referral / Provisional Diagnosis	Referral Discussed With At National Women's Fetal Medicine Service Date
All Scan Reports Attached? Yes <input type="checkbox"/> No <input type="checkbox"/>	First Antenatal Blood Results Attached? Yes <input type="checkbox"/> No <input type="checkbox"/>
Has Appointment Been Made Already? Yes <input type="checkbox"/> No <input type="checkbox"/>	Appointment Date Time



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

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Please complete all the details so Fetal Medicine Team can process the referrals as soon as possible.
Email: FetalMedicineScheduling@adhb.govt.nz
For urgent referrals phone: 09 307 4949 ext 29462.