



Antenatal Referral

Date of Referral: _____

ALL Antenatal Referrals are to be faxed directly to KEMH via fax **(08) 6458 1031** unless specified below.

Referring practitioner details

Name: _____ Provider number: _____

Practice address: _____

Practice telephone number: _____ Practice fax: _____

Health link details: _____

<p>Are you able to provide shared antenatal care for this patient if KEMH determines her to have a low risk pregnancy?</p>	<p>Yes</p> <p>No</p>
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Patient details

Full name: _____ Preferred name: _____

Known by another name? _____

DOB: _____ Gender: _____ ATSI status: _____

Address: _____

Mail address (if different): _____

Email: _____ Main telephone number: _____

Mobile: _____ Work: _____ Home: _____

Medicare Number: _____ Country of birth: _____

If no Medicare, please input Private Fund details: _____

URMN Hospital no. if known: _____

Interpreter needed: Yes No Language & dialect: _____

Patient details (continued)

Special needs:

Next of Kin / Guardian

Full name: _____

Relationship: _____ Phone no: _____

Referral details

Does this patient need to be seen within 7 days? Yes No

Is this patient suitable for Telehealth consult? Yes No

Which consultant / registrar was this discussed with

Name: _____ Site: _____ Date: _____

Are you requesting **pre conception care**? Yes No

please indicate specialist clinic requested: _____

This pregnancy

LMP: _____ Estimated date of delivery: _____

Confirmed by ultrasound Yes No Date: _____

Gravida: _____ Para: _____

Weight: _____ Height: _____ BMI: _____ BP: _____

Referral details (continued)

Significant past obstetric history

Yes

No

If yes, please detail below and include previous pregnancies and outcomes:

For the **current pregnancy**, are there any clinical concerns requiring specialist care?

Significant past medical history

Yes

No

If yes, please detail below:

Current medications:

Medication allergies:

Cervical screening test current

Yes

No

Not applicable

Results of antenatal tests attached

Yes

No

Results of ultrasounds attached

Yes

No

Referral details continued 

Models of pregnancy care and birth options

Patient name: _____

D.O.B: _____

Please indicate which model of care is requested

1. GP led Antenatal Shared Care with KEMH

GP provides low risk women (as determined by KEMH at 20 weeks visit) with antenatal care in first two trimesters of pregnancy, and women are then seen at KEMH at 36 weeks to plan further care.

Support is available during the pregnancy should concerns arise.

2. Community midwifery programme

Do not send referral to KEMH. Patient to apply directly via

<https://kemh.health.wa.gov.au/For-patients-and-visitors/Pregnancy-Patients/Community-Midwifery-Program>

3. Midwifery group practice

a) Hospital based Midwifery Group Practice or previous MGP if known

or

b) Family Birth Centre - *Do not send referral to KEMH*

Patient to apply directly via

<https://kemh.health.wa.gov.au/For-patients-and-visitors/Pregnancy-Patients/Family-Birth-Centre>

4. Hospital Midwifery Led antenatal Clinics

5. Obstetrician led antenatal care

This model of care is for women who have: indicate which applies

complicated medical history

previous pregnancy requiring specialist obstetric care

pregnancy that is not progressing normally

multiple pregnancy

Specialist Antenatal Clinics requested

Patients may be referred to more than one clinic if needed using this form

Patient name: _____

D.O.B: _____

1. Maternal fetal medicine team

All referrals for MFM go direct to unit via fax **08 6458 1031**

The MFM clinic is for women with complex high risk pregnancies (maternal and fetal disorders / diseases). Women may also be referred for preconception counselling & planning. Referrals relating to high risk pregnancies are triaged in the MFM Department, please include detailed information above.

2. Ultrasound / Imaging Services

CVS Amniocentesis Ultrasound
Fetal Anomaly

3. Childbirth and Mental Illness Service (CAMI Clinic)

please indicate which applies

Schizophrenia Bipolar Disorder
Prior history of Post Partum Psychosis

4. Women and Newborn Drug and Alcohol Service (WANDAS)

Alcohol Other drug use
Both

5. Diabetes Clinic

Type 1 insulin dependent diabetes
Type 2 diabetes
Gestational Diabetes <20 weeks
Preconception counselling

6. Adolescent and Young Women's Clinic

Age <19 years at expected date of delivery
Yes

7. Physicians Clinic

Preconception counselling
Medical review during pregnancy

Which hospital is patient booked to deliver at?

8. Placenta Accreta Clinic

For suspected placenta accreta, percreta or increta please provide copies of ultrasounds & detailed obstetric history

9. Preterm Birth Prevention Clinic

Please indicate if history of
preterm birth before 34 weeks gestation
uterine anomaly
significant cervical intervention
perinatal loss between 16-24 weeks

10. Genetic Services

Yes No

11. Additional services required

Social work
Psychological medicine
Dietitian

Antenatal first trimester routine tests required with this referral

Please include photocopies or arrange for copies of results of tests to be sent to the hospital.

Please indicate which tests you have arranged.

Full Blood Picture

Blood Group and Antibody screen

Hepatitis B surface antigen

Hepatitis C antibodies

HIV antibodies

Syphilis serology

Rubella IgG serology

Midstream urine mc&s

Chlamydia / Gonorrhoea screening

- Self Obtained Low Vaginal Swab (SOLVS)

Cervical screening Test (CST) within 5 years

Early dating ultrasound (if dates uncertain)

If patient has relevant risk factors:

Gestational Diabetes - Early Oral Glucose Tolerance Test

Vitamin D screening

Haemoglobinopathy screening

Fetal anomaly screening offered

Testing performed: Yes No *Please forward results of testing:*

a) Combined test = First trimester biochemistry (9-13+6 weeks) AND Nuchal translucency Ultrasound (11-13+6 weeks)

OR

b) NIPT blood test (8 weeks) AND Nuchal translucency Ultrasound (11-13+6 weeks)

OR

c) Second trimester screen if first trimester screen missed = NIPT preferred but maternal serum screen available as blood test at 15-17 weeks

Fetal Anatomy ultrasound scan at 18-20 weeks

(Please fax through results to 6458 1031)



Women and Newborn Health Service

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🌐 kemh.health.wa.gov.au

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in alternative formats on request.

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