

### Referral Form

DATE: \_\_\_\_\_ TIME: \_\_\_\_\_

REFERRING SERVICE:    EMERGENCY DEPT    SURGICAL    MATERNITY    GP    OBSTETRICIAN

AFFIX MRN LABEL HERE

GRAVIDA: \_\_\_ PARITY: \_\_\_ MISCARRIAGES: \_\_\_ TOP: \_\_\_ LMP: \_\_\_\_\_ GESTATION: \_\_\_ WEEKS

ABDOMINAL PAIN: NO YES COMMENT: \_\_\_\_\_

VAGINAL BLEEDING: NO YES COMMENT: \_\_\_\_\_

**PATHOLOGY & RADIOLOGY INVESTIGATIONS:**  
ALL WOMEN WHO PRESENT IN FIRST TRIMESTER WITH ABDOMINAL PAIN AND P.V. BLEEDING REQUIRE THE FOLLOWING BASELINE PATHOLOGY TESTS. IT IS PREFERABLE THAT THE WOMAN BE REFERRED TO HOSPITAL PATHOLOGY SERVICES.

FULL BLOOD COUNT	YES	NO
BETA HCG	YES	NO
BLOOD GROUP & RBC ANTIBODIES	YES	NO

ALL RHESUS NEGATIVE WOMEN WHO PRESENT WITH VAGINAL BLEEDING IN PREGNANCY REQUIRE COUNSELLING FOR ANTI-D. THE DOSE IS DEPENDANT ON THE GESTATION OF THE PREGNANCY. REFER TO RHESUS D POLICY DIRECTIVE AND DISCUSS WITH SENIOR STAFF OR O+G TEAM.

ANTI-D GIVEN: YES NO DOSE: \_\_\_\_\_

ULTRASOUND PERFORMED: YES NO SERVICE: CHHC BEACHSIDE COFFS HARBOUR

THE MEDICAL IMAGING DEPARTMENT HAS APPOINTMENTS AVAILABLE ON A DAILY BASIS FOR EPAS AND PCS. PERFORM AN E-ORDER IN POWERCHART OR PHONE EXT 7458 TO BOOK.

**DIAGNOSIS (PLEASE CIRCLE):**    INTRAUTERINE VIABLE PREGNANCY    THREATENED MISCARRIAGE  
MISCARRIAGE:    INCOMPLETE    MISSED    FETAL DEMISE    PREGNANCY OF UNKNOWN LOCATION

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

CLINICIANS NAME: \_\_\_\_\_

CLINICIANS SIGNATURE: \_\_\_\_\_

DESIGNATION: \_\_\_\_\_