South West Healthcare

HEALTHY MOTHERS HEALTHY BABIES - REFERRAL FORM

UR No:_____
SURNAME: _____
GIVEN NAME: _____
DOB:_____
ATTACH LABEL IF AVAILABLE

DATE OF THIS REFERRAL ALLERGIES? Yes ☐ No ☐ SAFETY ISSUES? Yes ☐ No ☐

Client Information:	
Full Name:	Date of birth :
Address:	Phone:
Does the client identify as Aboriginal or Torres Strait Islander?	Yes ☐ No ☐
Does the client need an interpreter? If yes, what language?	Yes ☐ No ☐
Partner/Support Person:	Phone:
Number of other children:	Other childrens' ages: / / / / / /
Emergency contact:	Phone:

Referral:	
HMHB provides support to pregnant women not accessing, or having difficulty accessing, ante-natal services due to a range of complex health, welfare and social issues, including but not limited to those outlined below.	
Pregnancy related health issues:	Yes ☐ No ☐
Mental health:	Yes ☐ No ☐
Drug or alcohol use:	Yes ☐ No ☐
Family Violence:	Yes ☐ No ☐
Homelessness or risk of homelessness:	Yes ☐ No ☐
Young parent/teen:	Yes ☐ No ☐
Refugee, asylum seeker or recently arrived migrant:	Yes ☐ No ☐
Sole parent family:	Yes ☐ No ☐
Isolation	Yes ☐ No ☐
Reason for referral:	

Referrer Details	
Name :	
Organisation:	Role:
Phone:	Email:
Address:	
HMHB to contact referrer before client? Day/times available to be contacted:	Yes ☐ No ☐

Safety:
Are there any safety issues for client or for workers? Please outline:

Pregnancy/ Health Information:		
Pregnancy due date:	Current number of weeks:	
Pregnancy choices discussed?		Yes ☐ No ☐
Happy to continue with pregnancy?		Yes ☐ No ☐
Intended birth venue:	Booking made?	Yes ☐ No ☐
Are they attending ante-natal services?		Yes ☐ No ☐
Number of previous pregnancies:		
Any complications with previous pregnancies?		Yes ☐ No ☐
Details:		
Health conditions (including allergies):		Yes ☐ No ☐
Please provide details including; medications prescribed, **allergies**, medical concerns and hospital admissions with this pregnancy:		

What other services is the client involved with:	
Organisation:	Contact details:

Client Consent:
I give permission for the Healthy Mothers Healthy Babies staff to share information with the agencies listed above.
Signed……Print Name……Date: / /

Referrer-Record of Client Verbal Consent
I have discussed the proposed referral with the client and I am satisfied that they understood the purpose of the referral and provided their informed consent for the Healthy Mothers Healthy Babies staff to share information with the agencies listed above.
Signed……Print Name ……Date: / /

SEND TO: Healthy Mothers Healthy Babies, South West Healthcare, Ryot St, Warrnambool, 3280, Ph: 5563 1259
Email: hmhb@swh.net.au, Fax 55631669

PRIVACY STATEMENT: The information collected on this form will not be disclosed to any other party except as required by law, or if you have given consent above. You can change or correct the information by contacting HMHB.

Office use only:

Priority: 1 ☐ 2 ☐

Checked preferred contact details? ☐

Appointment reminder required? SMS ☐ Email ☐ Phone call ☐

Preferred location? HV ☐ Clinic ☐