SWH Specialist Outpatient Clinics
Women's Health Service

Level 4, South West Healthcare
Ryot Street
Warrnambool VIC 3280

Tel: 03 5564 4363
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SPECIALITY REFERRAL FOR PREGNANCY / ANTENATAL CARE

NAME:
D.O.B:
ADDRESS:
CONTACT PHONE NUMBER/S:
EMAIL ADDRESS:
MEDICARE NUMBER: **Medicare Ref No:** **Expiry:**

IF MEDICARE INELIGIBLE
Private insurance fund: **Fund number:**
Nationality: **Language spoken:**

Dear Doctor,

REASON FOR REFERRAL: Pregnancy / Antenatal care

☐ **Requires EPAS <10weeks** (if yes, please comment in clinical details)

☐ **Shared Care with GP clinic**

LMP: **Blood Group:**
EDD:
Gravida & Parity: **G** **P**

Relevant Past History:
Current Medications:
Clinical Details:

☐ **Antenatal serology ordered**
☐ **Dating scan ordered**
☐ **13-week anatomy scan ordered** (if desired)

Prenatal testing (if desired):
☐ **First trimester combined screening** (including Nuchal Translucency ultrasound)
☐ **NIPT test**

PLEASE FORWARD THIS REFERRAL WITH ANY TEST RESULTS TO
SWH WOMEN'S HEALTH SERVICE PRIOR TO APPOINTMENT.
**** PLEASE NOTE: IF YOU ORDER ANY TEST,**
YOU ARE RESPONSIBLE FOR GIVING THE PATIENT THE RESULT.

Referring Doctor: **Provider No:**

Clinic: **Date:**

Signature: