Waitemata District Health Board

Best Care for Everyone

[*PLACE PATIENT LABEL HERE*]

First Name: _____ **Gender:** _____

Surname: _____ **Ph:** _____

Address: _____

Date of Birth: _____ **NHI#:** _____

Ward/Clinic: _____ **Consultant:** _____

Maternity

Post Term Referral

Woman's contact details: **Home:** **Mobile:** **Other:**
☐ LMC has recommended to the woman that consultation with a specialist is warranted because of prolonged pregnancy.

Current pregnancy: G P EDD: ☐ by scan ☐ dates	Significant Medical or Obstetric History:
Earliest scan: (please attach copy) Date: Gestation:	LMP: (very important if no 1st trimester scan) Dates: Cycle:

Clinical Indicators: (must meet ALL the following requirements)	
☐ Woman consents to post term referral	☐ No previous CS
☐ Healthy woman T+8 or greater	☐ Normal interval growth
☐ Age less than 40 years	☐ Normal foetal movements
☐ BMI less than 35	☐ No antepartum haemorrhage
☐ Satisfactory postdates USS report including BPP and liquor volume.	☐ Copy of two USS attached (earliest and postdates)

LMC Name:	Signature:	Date:
LMC Phone:	LMC Fax:	

Outcome:

☐ Suitable for IOL at 41+5 ☐ LMC to book IOL

or

☐ Requires Obstetric Clinic Appointment ☐ LMC to book clinic appointment or

☐ Clinic appointment made for:

Triaged by: **Signature:** **Date:**

Post Term Referral