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

Earliest scan: (please attach copy)
Date: ____________________________ Gestation: ____________________________

Significant Medical or Obstetric History:

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

☐ Requires Obstetric Clinic Appointment ☐ LMC to book clinic appointment

☐ Clinic appointment made for:

Triaged by: ____________________________ Signature: ____________________________ Date: ____________________________