

## Fetal Medicine Unit Services REFERRAL FORM

TE POAR HAUORA O WAITANA
CHRISTCHURCH WOMEN'S HOSPITAL
FETAL MEDICINE UNIT

REFERRER:

Referral from other DHBs need to come from the referring DHB consultant

DATE: ....../....../......

Please provide all the information requested to allow us to process your referral as speedily as possible		
PATIENT DETAILS		
NHI:	DOB:/	
Name:		
Address:		
Home ph: ( )	Mobile:	
Ethnicity: NZ European NZ Maori Asian	Pacific peoples Middle Eastern/Latin American/	
Other:	/Africa	
Interpreter required: Yes Language:		
PARTNER Name:		
BOOKING FORM Date sent:/	☐ enclosed ☐ to follow	
LMC Name:	Contact ph: Fax:	
CONSULTANT Name:	Contact ph:	
GP Name:	Contact ph:	
DETAILS OF THIS PREGNANCY		
LMP:	G: P:	
USS CONFIRMED EDD:/ WEI	GHT: (kg) HEIGHT: (m)	
First antenatal screen completed  Out of Canterbury DHB p	please send all blood results	
NUCHAL TRANSLUCENCY and MSS		
NT Scan completed on:/ Where	performed:	
Screening requested: MSS1 MSS2 Declined		
NIPS Yes No Date:/		
NIPS undertaken following referral. Inform FMU directly, this may		
ULTRASOUND SCAN: If out of Canterbury DHB please send all Date of latest scan:	ultrasound reports / make images available to review	
RESULT / REASON FOR REFERRAL		
TI: ( )		
This referral has been discussed with a Clinician at Christchurch V MW / Dr	vomen's Hospital please record name of	
· · · · · · · · · · · · · · · · · · ·	ent given	
FMU APPOINTMENT	g	
Date:	vised by  letter sent/	
	texton//	
	☐ phone on/	
FETAL MEDIC		
Ground Floor, Christchurch Women's Hospital Private Bag 4711, Christchurch	Telephone: (03) 364 4557 or internal 85557 Fax: (03) 364 4411 or internal 85411	
O&G Consultants: Dr Su Chandru, Dr Pippa Kyle,	Dr Shelly Mather, Dr Jerome Mayers, Dr Rosemary Reid.	
Midwives: Fetal Medicine Midwifery Team		

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