Maternal Fetal Medicine Referral

Capital & Coast District Health Board
ŪPOKO KI TE URU HAUORA

Women's Health Service

Please complete all the details so the Maternal Fetal Medicine Team can process the referral promptly.

Date of referral:		
Patient name:	Patient address:	Patient phone (home):
Date of birth	NHI	(mobile):
Referrer name:	Referrer address:	Referrer phone contact:
LMC name:	LMC address:	LMC phone contact:
GP name:	GP address:	GP phone contact:

LMP:	EDD (USS confirmed):	Gravida:	Para:

Blood group:	1st Antenatal blood results attached: Yes ☐ No ☐
Antenatal screening results attached: Yes ☐ No ☐	
Date of last USS:	Last USS report enclosed Yes ☐ No ☐
Nuchal translucency (NT) scan performed Yes ☐ No ☐	All USS reports attached Yes ☐ No ☐
Result of NT scan:	
Reason for referral / provisional diagnosis:	
Referral discussed with:	Date discussed with MFM:
Has appointment been made already Yes ☐ No ☐	Appointment: Date: Time:

Referrals can be emailed with supporting documentation to:

From 0800-1630hrs – Referrals are prioritised daily by one of our fetal medicine consultants
For urgent communication – Contact MFM sub-specialist on call via Hospital Switchboard *Or*
MFM Midwife Phone: 0211998223 (Wellington Hospital)
For any **urgent or urgent out of hours** communication please contact the on call Obstetric Consultant, through the Wellington Hospital switchboard