

REQUEST for OUTPATIENT APPOINTMENT to King Edward Memorial Hospital for Women

Please make an appointment for this patient to attend: <i>(please tick)</i> <input type="checkbox"/> <i>Obstetric</i> <input type="checkbox"/> <i>Gynaecology</i> <input type="checkbox"/> <i>Oncology</i> <input type="checkbox"/> <i>Genetic</i> <input type="checkbox"/> <i>Urology</i> <input type="checkbox"/> <i>Menopause</i> <input type="checkbox"/> <i>Fertility</i> <input type="checkbox"/> <i>Other</i>											
Family Name:	Next of Kin / Guardian										
First Name(s):	Relationship: _____ Family Name: _____ First Name: _____										
Maiden Name: Retained: Y / N Other Name:	Has the patient previously been seen by this hospital? Y / N Name registered: _____ Year of last attendance: _____										
Address:	Is an interpreter required? Y / N If Yes, Language / dialect: _____										
Postcode:	Telephone No: Home: _____ Mobile: _____										
Birth Date: <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table> Age:											Marital Status: S / M / W / D / Sep / Defacto
Med Rec No: <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>											Country of Birth:
Referring doctor stamp (or) Name Phone Address											

If other than Obstetric Patient PTO →

If Obstetric Patient We would like to share antenatal care with you, both before and after the first clinic visit (usually at 19 weeks). <input type="checkbox"/> I do not wish to be involved in shared care	
Gravida:	Parity: EDD (by dates):
LMP:	EDD (by ultrasound):

Please forward photocopies or arrange copies to be sent to KEMH of results of tests listed below. Place a ✓ (tick) beside the test if you have, or will, arrange the test.

Full Blood Picture	Pap Smear (within 2 years)
Group and atypical antibodies	Midstream Sterile Urine
Early dating ultrasound (if dates uncertain)	HIV
Rubella antibodies	Hep B surface antigen Hep C antibodies
Syphilis antibodies	Fetal anatomy U/S (18 to 20 weeks)
Chlamydia	Glucose challenge test (if indicated)
1 st trimester screen (11 to 13 weeks) or maternal serum screening (15 to 17 weeks)	Other:

Indicate specialist service/s that you believe need to see this patient at KEMH before 19 weeks, please state reason over page

- Adolescent* *Drug and Alcohol* *Diabetes* *Dietitian* *Genetic* *Medical*
 Maternal Fetal Medicine (high risk) *Psychological Medicine* *Social Work* *Other*

Referral Letter

Signature: _____

Date: _____

Please return this form to:

King Edward Memorial Hospital for Women (KEMH), 374 Bagot Road, Subiaco WA 6008
or by Fax to: (08) 9340 1031