Bayside Health Peninsula Care Group
Women's Services

REFERRAL
FETAL DIAGNOSTIC SERVICE

UR NUMBER .....

SURNAME .....

GIVEN NAMES .....

DATE OF BIRTH .....
Please fill in if no Patient Label available

App.19/2/26 Print Code:17433

PHF352760v

Referral Date: ...../...../.....

Gestation@referral: .....

Referral to: *Dr. Nisha Khot*

Fetal Diagnostic Service
Women's Services Antenatal Clinic
Outpatient Area 1 Building D
Peninsula University Hospital

Phone: 9784 2600
Fax: 9125 9846
If Urgent Ring: 9784 2647

Referring Doctor:

Name: .....

Contact number *(mobile preferred)*: .....

Provider Number: .....

Signature: .....

An ultrasound request must be completed for a referral to be accepted.

Ultrasound request completed: ☐ Yes ***Referral must begin 'FDS Ultrasound"***

Spoken Language: ..... Interpreter Required: ☐ Yes ☐ No

	LMP:	EDD:	Gravidity	Parity	BMI
Pregnancy:	...../...../.....	...../...../.....	.....	.....	.....

Patient referral for:

☐ Fetal diagnostic invasive testing (indicate below)

☐ CVS ☐ Amniocentesis ☐ Fetal diagnostic ultrasound

Reason for referral: .....

.....

Indication: ☐ Abnormal screening test ☐ High risk of genetic anomaly *(eg FH, previous affected baby)*
☐ Abnormal ultrasound finding ☐ Maternal infection ☐ PI accreta
☐ Vasa Praevia ☐ severe IUGR ☐ MCDA Twins

Aneuploidy screening: ☐ Declined ☐ NIPS ☐ FTCS ☐ T2MSS Result: .....

US reports: ☐ Yes ☐ No

Past Obstetric History: .....

.....

Prior Genetic Counselling: ☐ Yes ☐ No Who provided counseling: .....

Family History: .....

.....

Medical History / Drugs / Allergies: .....

.....

What counselling has been provided:

☐ Verbal ☐ Written Information ☐ Referred to Monash Genetics Services

GP Name & Practice Address *(if not referred by GP)* .....

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Ensure that the following are included:

☐ ultrasound reports ☐ antenatal screening test results ☐ blood group and antibody result

.....	.....	.....	.....
Signature	Print Name	Designation	Date / Time

REFERRAL FETAL DIAGNOSTIC SERVICE

MR/352760

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