Peninsula Health
Women's Services

REFERRAL
FETAL DIAGNOSTIC SERVICE

UR NUMBER .....

SURNAME .....

GIVEN NAMES .....

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

App.13/12/2024 Print Code:17433

PHF35276 0v

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

Referral to: *Dr. Nisha Khot*

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

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

Referring Doctor:

Provider Number .....
Signature:

Patient referral for: ☐ Fetal diagnostic ultrasound ☐ Fetal diagnostic invasive testing (indicate below)
☐ CVS ☐ Amniocentesis

Title: ..... Given Name: ..... Surname: .....

Contact Phone Number: ..... Partner's Name: .....

Patient Address: .....

Date of Birth: ...../...../..... Medicare Card Number: .....

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

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

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

Details: .....

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Past Obstetric History: .....

.....

Family History: .....

.....

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

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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 in the referral:

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

Office Use Only

Received: ...../...../.....

Triaged: ...../...../.....

Outcome: Accept / Reject
More information required

Ultrasound
Booked : ...../...../.....

ANC
Booked : ...../...../.....

Pt & Dr Notified: Phone / Mail

Date Notified: ...../...../.....

REFERRAL FETAL DIAGNOSTIC SERVICE

MR/352760

13/12/2024 Print Code:17433 Referral Link