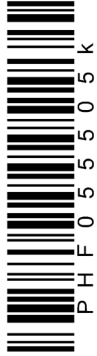


**REFERRAL
WOMEN'S SERVICES
ANTENATAL CLINIC**

Peninsula Health Use Only ↓

UR NUMBER
SURNAME
GIVEN NAMES
DATE OF BIRTH
Please fill in if no Patient Label available App.17/4/2024 Print Code:14919



Referral to: *Dr. Nisha Khot*
Women's Services Antenatal Clinic
Outpatient Area 1 Building D
Frankston Hospital
Frankston VIC 3199
Fax: 9125 9846
Antenatal Clinic PH: **9784 2626** - For Clinical
Concerns or Urgent Referral
Appointment Enquiries **PH: 9784 2600**
E-referral via Mastercare is preferred.

Referring Doctor (Stamp):

Provider No:

Title: Given Names: Surname:
Previous Surname (if applicable): Medicare Card No:
Patient Address:
Date of Birth:/...../..... Preferred Contact Number:
Language Spoken: Interpreter Required: Yes No
Indigenous Status: Aboriginal Torres Strait Islander Neither
Country of Birth: Ethnicity:
Next-of-Kin Name: Relationship to Patient: Contact Number:

Mandatory Referral Information:

EDD:/...../..... Based on LNMP:/...../..... US Dating Scan
Ht:m Wt:kg BMI:kg/m2 BP:/.....mmHg

Blood Test: Attached Pathology Service
Ultrasound: Attached Radiology Service
First Trimester Screening:.. Attached Pending Laboratory Service

Relevant Current and Past History (Please attach additional referral letter if appropriate)

Obstetric history: Grav Para Risk Factors
.....
.....

Past medical history:
.....
.....

Medications:

Allergies:

Referrer's Name

Signature

Designation