Print | Reset Form

Queensland Government

Royal Brisbane & Women's Hospital

MATERNAL FETAL MEDICINE (MFM) REFERRAL FOR IMAGING AND CONSULT

To: Dr Renuka Sekar MBBS DGO FRANZCOG CMFM
Director Maternal Fetal Medicine CAPC

Metro North Health Service District
Centre for Advanced Prenatal Care
Level 6, Ned Hanlon Building
Butterfield Street Herston Qld 4029

(Affix RBWH patient identification label here or write details below)

RBWH URN: .....

Family name: .....

Given names: .....

Date of birth: ..... Sex: ☐ M ☐ F ☐ I

Address: .....

Phone: ..... Mobile: .....

Medicare No: ..... Ref No: .....

Expiry Date: **Ineligible Patient:** ☐ Yes ☐ No

Email Referral to:
MNCPI_Referral@health.qld.gov.au
Fax Referral to: 1300 364 952

If urgent also call Doctor or Midwife on **(07) 3646 0840**

INCOMPLETE REFERRALS WILL BE DECLINED

REFERRAL DOCTOR DETAILS

Request date: .....

Referring Doctor name: .....

Referring Doctor provider number: .....

Referring Doctor contact number: .....

Obstetric Consultant name: .....

Address / Department: .....

.....

Referring Doctor signature: .....

MANDATORY - CLINICAL DETAILS

EDC: ..... / ..... / ..... by ☐ LMNP ☐ Scan

G: ..... **P:** ..... **M:** ..... **O:** .....

Current BMI (mandatory):

Please upload images to PACS and attached all previous ultrasound reports and blood results

Full antenatal blood screen at:

☐ QML ☐ S&N ☐ NIPT ☐ CFTs ☐ Other: .....

Obstetric / Medical history: .....

.....

.....

.....

.....

.....

.....

A/N Serology: .....

.....

Infectious Status (MRSA/VRE): .....

.....

Allergies: .....

.....

Medications: .....

.....

.....

EXAMINATION REQUIRED (tick below)

☐ Nuchal translucency +/- karyotype (11+3 wks – 13+6wks)

☐ 18 – 20 week morphology ultrasound

☐ Tertiary ultrasound

Serial scans as requested (tick reason)

☐ Multiple pregnancy

☐ Rh disease / alloimmunisation

☐ Fetal growth and wellbeing ultrasound

☐ Cervical length measurement:

☐ Other: .....

.....

.....

Details: .....

.....

.....

MFM PROCEDURES

☐ **CVS - 11–14 weeks**

☐ **Amniocentesis from 16 weeks**

☐ **Fetal echocardiography and consultation**

☐ **Discussed with patient**

COUNSELLING

☐ **Preconception counselling**

☐ **Termination of Pregnancy options counselling**

All genetic counselling should be referred to Genetic Health Queensland

OFFICE USE ONLY (MFM Staff)

Date received: Actioned:

Triaged by: .....

Comments: .....

Appointment date: Time:

Accession No.: .....

Doctor: .....

☐ Appointment confirmed with patient

Report: ☐ **Sent with patient** ☐ **Faxed to referring doctor**

MATERNAL FETAL MEDICINE REFERRAL FOR IMAGING AND CONSULT

MR C 6130 v10.00 - 08/2022 *Locally Printed*
00201:06130