



Queensland Government

Royal Brisbane & Women's Hospital

MATERNITY DIETITIAN OUTPATIENT REFERRAL

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Address:

Mobile phone:

Date of Birth:

Sex: M F I

Please fax completed form to RBWH Maternity Outpatient Department: (07) 3646 5482

Referrer name: Date: / /

Contact:

Interpreter required: No Yes, language: Patient consented to referral

Maternity care:

- GP shared care Tertiary care RBWH Midwives (Pegasus, Phoenix)
- RBWH Community Midwives (Nundah) Birth Centre Midwives
- Midwifery Group Practice (Ngarrama, Aurora, Aster) Private Practice Obstetrician Private Practice Midwives

Pre-pregnancy wt: Ht: BMI: kg/m² Gestation: /40 Current wt:

Patient appointment preference:

Align with other RBWH appointments: Mon Tues Wed Thurs Fri AM PM

Referral reason:

Above a healthy weight pre-pregnancy (BMI>25kg/m²) or gaining weight too quickly

Living Well during Pregnancy is a **telephone coaching program** to support healthy eating, getting active and achieving a healthy pregnancy weight gain. Self-referral available. For women who require an interpreter, a face-to-face appointment will be booked in MOPD. Cat 1C (within 30 days)

Required patient information:

Mobile number: Preferred contact number (if different):

Email:

Call preference, day: Tues Wed Thurs Fri Time: 7.30-9am 9am-12pm 12-3pm 3-5pm

Hyperemesis (uncontrolled morning sickness) Cat 1B (within 10 days)

Previous weight loss surgery (gastric sleeve, bypass, or band) Cat 1B (within 10 days)

Low pre-pregnancy body weight (BMI<18.5kg/m²) or low gestational weight gain Cat 1B (within 10 days)

Other (please specify):

Name: Designation: Signature: Date: / /

Administration use only

Appointment scheduled: / / (see preference above) If required, interpreter booked: Yes No

Patient notified: Appointment letter (>2/52) Text message sent (<2/52) Appointment summary provided Phoned

Referral form sent for scanning (Priority 3 if appointment next business day)

Administrative Officer name: Signature: Date: / /

Living Well during Pregnancy program only:

Participant manual: Hardcopy provided **or** Hardcopy posted **or** Digital copy emailed

Participant survey: Emailed **or** Text message sent

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All clinical form creation and amendments must be conducted through Health Information Services

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