



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

Model of care: .....

Pre-pregnancy wt: ..... Ht: ..... BMI: ..... kg/m<sup>2</sup> Gestation: ..... /40 Current wt: .....

Patient appointment preference: :  Face-to-face  Phone

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

### Referral reason:

Above a healthy weight pre-pregnancy (BMI>25kg/m<sup>2</sup>) 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 information:

Preferred contact number (if different): .....

Email: .....

Hyperemesis (severe nausea and vomiting) 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/m<sup>2</sup>) or low gestational weight gain Cat 1B (within 10 days)

Eating disorder (current or history) Cat 1B – Monday PM clinic (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

DO NOT WRITE IN THIS BINDING MARGIN

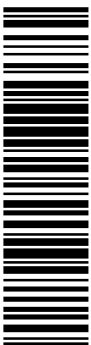
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All clinical form creation and amendments must be conducted through Health Information Services

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