**MATERNITY DIETITIAN OUTPATIENT REFERRAL**

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

<table>
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<tr>
<th>Referrer name:</th>
<th>Date: <strong>.</strong>.__</th>
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**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)

**Living Well during Pregnancy program only:**

- Participant manual:  [ ] Hardcopy provided  [ ] Hardcopy posted  [ ] Digital copy emailed
- Participant survey:  [ ] Email  [ ] Text message sent