Queensland Government

Royal Brisbane & Women's Hospital

MATERNAL FETAL MEDICINE (MFM) REFERRAL FOR IMAGING AND CONSULT

To: Dr Renuka Sekar MBBS DGO FRANZCOG CMFM
Clinical Lead 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

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

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

REFERRAL DOCTOR DETAILS

Request date: ..... / ..... / .....

Referring Doctor name: .....

Referring Doctor provider number: .....

Obstetric Consultant name: .....

Referring Doctor fax: .....

Address / Department: .....

.....

Referring Doctor signature: .....

MANDATORY - CLINICAL DETAILS

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

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

Current BMI *(mandatory)*: .....

BMI >40 Pathway:
- NT Scan (11+3 - 13+6 weeks)
- TV Scan (14 - 16 weeks)
- Morphology Scan (22 weeks)
- Growth Scan (28 - 32 weeks)

Blood group / antibody screen *(Mandatory for invasive test, 1st trimester screen, nuchal scans)*

☐ QML ☐ S&N ☐ Other: .....

Obstetric / Medical history: .....

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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

TERTIARY OBSTETRIC ULTRASOUND
(Previous Ultrasound Reports Must Be Attached)

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

☐ 18 – 20 week morphology ultrasound

☐ BMI >40 Pathway scans

☐ Tertiary ultrasound

Details: .....

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Serial scans as requested (tick reason)

☐ Multiple pregnancy

☐ Rh disease / alloimmunisation

☐ Fetal growth and wellbeing ultrasound

☐ Cervical length measurement: .....

☐ Other: .....

.....

MFM PROCEDURES

☐ **CVS - 11–14 weeks**

☐ **Amniocentesis from 16 weeks**

☐ **Fetal echocardiography and consultation**

COUNSELLING

☐ **Preconception counselling**

☐ **Pregnancy options counselling**

COMPULSORY PATIENT ID CHECK (3Cs) BY MFM

☐ Patient identification verified

☐ Procedure and consent verified

☐ Correct patient data

MFM Staff Name *(print)*: .....

Designation: .....

Signature: .....

MATERNAL FETAL MEDICINE REFERRAL FOR IMAGING AND CONSULT

DO NOT WRITE IN THIS BINDING MARGIN

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

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