F2000

mater
maternal fetal medicine
women's imaging

# REFERRAL

Unit Record No. _____

Surname _____

Given Names _____

DOB _____ Sex _____

AFFIX PATIENT IDENTIFICATION LABEL HERE

**For appointments phone Mater Maternal Fetal Medicine, Women's Imaging: (07) 3163 1896**

## Referral To

Date of referral: ..... / ..... / .....

Referral to:

☐ Dr Glenn Gardener ☐ Dr Scott Petersen ☐ Prof Sailesh Kumar ☐ Dr Joseph Thomas ☐ A/Prof Rob Cincotta ☐ Dr Jackie Chua

## Patient Details

| Name (please print): | Date of birth: ..... / ..... / ..... |
|---|---|
| Address: | |
| Contact number: | Medicare number: |

## Examination Request

☐ Early pregnancy
☐ 1st trimester screening
NIPT performed: ◯ Yes ◯ No
☐ Morphology ultrasound (19–22$^{+6}$)
☐ Tertiary ultrasound
☐ Growth and Dopplers
☐ Chorionic Villus Sampling (CVS)/amniocentesis
☐ Other *(specify)*: .....
☐ Consultation
☐ External Cephalic Version (ECV)
☐ Cervical length

## Clinical Information

| ☐ Multiple pregnancy | EDC: ..... / ..... / ..... | Gestation requested: |
|---|---|---|

Notes:

## Copy Report To

## Referrer Doctor Details

| Name (please print): | |
|---|---|
| Provider number: | Contact number: |
| Address: | |
| Signature: | |

**Mater Maternal Fetal Medicine, Women's Imaging. Level 7 Mater Mothers Hospital, South Brisbane Qld 4101**
**Phone: (07) 3163 1896 Fax: (07) 3163 1890 Email: mfm@mater.org.au**





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