Metropolitan Referral Unit - Obstetric/Neonatal Referral Form

Government of South Australia
SA Health

Health Care @ Home (HC@H)
Please complete form and fax to **1300 546 104** or phone **1300 110 600**

Referral source ☐ Public hospital ☐ Mental Health ☐ GP ☐ Other

PATIENT INFO Sticker/MR10/UR No: _____
Surname: _____
First name: _____
Address: _____
Suburb: _____ P/Code: _____
Address where care to be provided (if not usual address)
Address: _____
Suburb: _____ P/Code: _____
☐ Male ☐ Female ☐ DOB: ____ /____ /____
Telephone: _____
Mobile: _____
NOK: _____
Relationship: _____
Telephone: _____

DATE OF REFERRAL: ____ /____ /____ Time: _____
Referring hospital/agency: _____
Admission date: ____ /____ /____ Discharge date: ____ /____ /____
Ward/unit: _____ Ext no: _____
Referrer's name: _____
Requested commencement date: ____ /____ /____
General Practitioner: _____
Address: _____
_____ P/Code: _____
Telephone: _____
Country of birth: ☐ Australia ☐ Other: _____
Interpreter required? ☐ No ☐ Yes, type: _____
Health fund: ☐ No ☐ Yes, fund name: _____
Membership no: _____
Allergies: _____

INDIGENOUS STATUS: ☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither ☐ Unknown
Usual living arrangements: ☐ Alone ☐ With carer ☐ With spouse ☐ Homeless ☐ Independent living unit

PRIMARY DIAGNOSIS: MOTHER
Midwife _____ and/or obstetrician _____
G _____ P _____ Blood group: _____ Hb _____
☐ NVD ☐ LSCS ☐ Instrumental ☐ Ventouse
Anaesthetic/analgesia: _____
Complications: _____
Placenta: _____ Membranes: _____
Perineum/wound: _____
Breast: _____ Nipples: _____
Serology: _____

NEONATE: Paediatrician _____ Gestation _____ /40
DOB: ____ /____ /____ Time: _____ Apgars _____ /_____
Vitamin K ☐ Yes ☐ No Date: ___ /___ /___ ☐ Oral ☐ IM
Neonatal Screening ☐ Yes ☐ No Date: ____ /____ /____
Hearing test ☐ Yes ☐ No Date: ____ /____ /____
Phototherapy ☐ Yes ☐ No Date: ____ /____ /____
☐ Neonatal care Reason: _____
☐ BF ☐ AF Frequency: _____ Concerns: _____
Birth weight: _____ g Discharge weight: _____ g
Serology: _____ Sex: ☐ Male ☐ Female

Secondary conditions: eg diabetes, epilepsy, methadone program, PND
Mother _____
_____
Neonate _____
Care required _____
☐ Routine postnatal care ☐ Feeding assistance ☐ Neonatal care (weight, check) ☐ Removal of sutures/staples
☐ Wound dressing ☐ NNST ☐ Medication administration/assessment ☐ Other
Attached: ☐ Medication authority ☐ Medication authority
Known hazards/alerts (eg animals, aggression): _____
Other relevant information: _____

CURRENT COMMUNITY REFERRAL AND NEW REFERRAL/S made on completion of package

Service	Current Y/N	Details - contact name and phone number	Referred Date

Referrer's signature: _____ Position: _____
Contact details: _____ Date and time faxed: _____

OFFICE USE ONLY														
☐ A1	☐ A2	☐ A3	☐ B1	☐ B2	☐ B3	☐ CR1	☐ CR2	☐ CR3	☐ CC1	☐ CC2	☐ CC3			
☐ D1	☐ D2	☐ D3	☐ E2	☐ E3	☐ F1	☐ F2	☐ F3	☐ G1	☐ G2	☐ G3	☐ H1	☐ H3		
☐ I	☐ JS	☐ JI	☐ K2	☐ K3	☐ LE1	☐ LC1	☐ LR2	☐ LE3	☐ LC3	☐ LR3	☐ M1	☐ M2		
☐ M3	☐ N-CW	☐ EN	☐ RN1	☐ RN2	☐ CPC	☐ PT	☐ OT	☐ SP	☐ SW	☐ DT	☐ SAFT	☐ INT		