Maternal Fetal Medicine Referral

Te Whatu Ora
Health New Zealand

Women's Health Service - Capital, Coast

Please complete all the details so the Maternal Fetal Medicineκ ² ņƘ wdzl· Team can process the referral promptly.

Date of referral:	NHI:	
Patient name:	Patient address:	Patient phone (landline) (mobile):
Date of birth	Patient email:	
Referrer name:	Referrer address:	Referrer phone contact:
LMC name:	LMC address:	LMC phone contact:
GP name:	GP address:	GP phone contact:

LMP:	EDD (USS confirmed):	Gravida:	Para:
Blood group:	1st Antenatal blood results attached: Yes ☐ No ☐		
Antenatal screening results attached: Yes ☐ No ☐			
Date of last USS:	Last USS report enclosed Yes ☐ No ☐		
Nuchal translucency (NT) scan performed Yes ☐ No ☐		All USS reports attached Yes ☐ No ☐	
Result of NT scan:			
Reason for referral / provisional diagnosis:			
Referral discussed with:		Date discussed with MFM:	
Has appointment been made already Yes ☐ No ☐	Appointment: Date: Time:		

Referrals can be emailed with supporting documentation to: RES-MFMReferrals@ccdhb.org.nz

From 0800-1630hrs – Referrals are prioritised daily by one of our fetal medicine consultants
For urgent communication – Contact MFM sub-specialist on call via Hospital Switchboard *Or*
MFM Midwife Phone: 0211998223 (Wellington Hospital)
For any **urgent or urgent out of hours** communication please contact the on call Obstetric Consultant, through the Wellington Hospital switchboard