


# JHH Maternity Services

Step guide to referral forms on  
Community Health Pathways

17 June 2020



**Health**  
Hunter New England  
Local Health District

 **Community HealthPathways**

Hunter New England

- Home
- COVID-19
- About HealthPathways
- Acute Services
- Allied Health Referrals
- Child Health
- Care in the Last 12 Months of Life
- Investigations
- Lifestyle & Preventive Care
- Medical
- Mental Health
- Older Persons' Health
- Therapeutics
- Public Health
- Specific Populations
- Surgical**
- Women's Health**
- Our Health System
- Service Directories

**Women's Health** ▾

**In This Section**

- [Breastfeeding](#)
- [Contraception and Sterilisation](#)
- [Gynaecology](#)
- [Pregnancy Related Conditions](#)
- [Maternity and Gynaecology Referrals](#)**

**In This Section**

- [COVID-19 Changes to Maternity Care](#)
- [Early Pregnancy Assessment](#)
- [Gynaecological Cancer Referrals](#)
- [Acute Gynaecology Referrals](#)
- [Non-acute Gynaecology Referrals](#)
- [Hysteroscopy Outpatient Service](#)
- [Lactation Consultants](#)
- [Long Term Contraception Referrals](#)
- [Maternal Fetal Medicine Unit](#)
- [Maternity Referrals](#)**
- [Maternity - Urgent Referrals](#)
- [Perinatal Education](#)
- [Tongue Tie Release Providers](#)

**Newcastle / Lake Macquarie / Port Stephens** ▾

# Newcastle / Lake Macquarie / Port Stephens ^

## Private

- [Obstetricians](#) v
- [Midwives](#) v

## Public ^

If referring for routine pregnancy care provide patient with [general](#) and specific [maternity unit](#) information.

Low risk antenatal referrals sent to the John Hunter Hospital from outside the [Greater Newcastle Sector](#) will be redirected to the woman's [local maternity unit](#). The John Hunter Hospital will continue to function as a Level 6 tertiary referral obstetric service for higher risk pregnancies for the HNE LHD.

## John Hunter Hospital

John Hunter Maternity offers these [services](#) and [models of care](#). The pages below outline the redesigned processes for routine referrals.

[All new referrals](#) v.

[Patients already booked](#) v.

## All new referrals ^.

1. Be aware of changes to maternity care for:
  - [initial appointment](#) v.
  - [ongoing pregnancy care](#) v.
2. Prepare the [required information](#) v.
3. To refer:
  - Use SeNT (preferred), or fax both referrals to a named specialist via Maternity and Maternal Fetal Medicine Unit (MFM) Outpatients via the same fax number, **(02) 4923-6525**:
    - [referral for antenatal care form](#), and
    - [concurrent MFM referral for first-trimester risk assessment](#).
  - Referral for antenatal care and referral for first trimester risk assessment is available through e-referrals.
  - Provide the patient with referral for FTS bloods (PAPP-A, beta-hCG and PIGF) to be collected at >10+0 weeks and 1 week prior to scheduled appointment in the MFM. The preferred pathology provider is NSW Health Pathology as the patient will be bulk billed and international units are provided to streamline processing of results.
  - Give patients a copy of all blood results and available scans (dating scans are not required if last menstrual period (LMP) is known and patient has a regular cycle), to bring to their hospital visits.

**2 Referral Forms are required for Maternity Care**

**Fax to 49 23 6525.**

## Referral for Antenatal Care

## Referral for Screening Trimester Screening Service

JOHN HUNTER HOSPITAL MATERNITY SERVICE REFERRAL FOR ANTENATAL CARE	
Referral for patient already booked from antenatal care: <input type="checkbox"/> No <input type="checkbox"/> Yes	
This referral is for: <input type="checkbox"/> URGENT <input type="checkbox"/> NON-URGENT	Preferred model of care: <input type="checkbox"/> Shared Care <input type="checkbox"/> Midwife Care
Name: _____	D.O.B.: _____
Address: _____	Telephone: (02) _____
Does patient require an interpreter: <input type="checkbox"/> No <input type="checkbox"/> Yes Language spoken: _____	Indigenous Status: <input type="checkbox"/> Aboriginal / Torres Strait Islander <input type="checkbox"/> Other: _____
No. of pregnancies: _____ No. live births: _____ LMP / EDC: _____	EDS Score: _____ GDM: _____
<b>Significant Past Medical History</b>	
<input type="checkbox"/> Infection (HIV, Hep C) <input type="checkbox"/> Autoimmune <input type="checkbox"/> Renal <input type="checkbox"/> Rheumatological	<input type="checkbox"/> Cardiac <input type="checkbox"/> Respiratory <input type="checkbox"/> Hypertension <input type="checkbox"/> Endocrine
<input type="checkbox"/> Diabetes <input type="checkbox"/> GI <input type="checkbox"/> Clotting Disorder <input type="checkbox"/> Neurological	<input type="checkbox"/> Psychiatric <input type="checkbox"/> Substance Abuse <input type="checkbox"/> Other: _____
Diagnosis / Comments: _____	
<b>Significant Past Obstetric History</b>	
<input type="checkbox"/> Recurrent Miscarriage <input type="checkbox"/> IUGR - delivered <4 wks <input type="checkbox"/> Intra PTB requiring transfusion	<input type="checkbox"/> Intra Abruption <input type="checkbox"/> Cordal Compromise <input type="checkbox"/> Placental - delivered > 36 wks
<input type="checkbox"/> LPS <input type="checkbox"/> Fetal Anomaly / Genetic Disorder <input type="checkbox"/> Other: _____	Diagnosis / Comments: _____
<b>Issue This Pregnancy</b>	
<input type="checkbox"/> Term/Pre-term events (e.g. Stillborn) <input type="checkbox"/> Hypertension <input type="checkbox"/> Fetal Anomaly	<input type="checkbox"/> GHY / Blood Group Antibodies <input type="checkbox"/> Gest Diabetes <input type="checkbox"/> IVF Pregnancy <input type="checkbox"/> Substance Abuse
<input type="checkbox"/> Surface Blood Transfusion <input type="checkbox"/> Recurrent Bleeding <input type="checkbox"/> Low lying Placenta <input type="checkbox"/> Smoker > 27 Day	<input type="checkbox"/> Maternal Age < 18 or > 35 <input type="checkbox"/> Increased Risk > 1: Other: _____
Diagnosis / Comments: _____	
<b>Significant Family History</b>	
<input type="checkbox"/> Congenital Cardiac <input type="checkbox"/> Clotting Disorder <input type="checkbox"/> Genetic <input type="checkbox"/> Other: _____	Diagnosis / Comments: _____
<b>Additional Test Results - Please attach copies of all relevant results.</b>	
Please specify: _____	

JOHN HUNTER HOSPITAL MATERNITY SERVICE CONCURRENT REFERRAL FOR FIRST TRIMESTER SCREENING SERVICE	
This referral is only valid for women planning or eligible for public antenatal care through one of the following pathways: (1) referral to the MFM Unit for antenatal care; (2) referral to the MFM Unit for antenatal care; (3) referral to the MFM Unit for antenatal care; (4) referral to the MFM Unit for antenatal care.	
In Referral Path: <input type="checkbox"/> Antenatal Care <input type="checkbox"/> First Trimester Screening <input type="checkbox"/> Both Antenatal Care & First Trimester Screening	Referral Path: <input type="checkbox"/> Antenatal Care <input type="checkbox"/> First Trimester Screening <input type="checkbox"/> Both Antenatal Care & First Trimester Screening
Dr Bronwyn Andrew (FRACOL, DOL, OBA) <input type="checkbox"/> Dr New York (FRACOL, DOL, OBA) <input type="checkbox"/> Dr Maria Morris (FRACOL, DOL, OBA) <input type="checkbox"/> Dr Nicola Manderson (FRACOL, DOL, OBA) <input type="checkbox"/> Dr Helen Spence (FRACOL, DOL, OBA)	Dr Nicola Manderson (FRACOL, DOL, OBA) <input type="checkbox"/> Dr Helen Spence (FRACOL, DOL, OBA) <input type="checkbox"/> Dr Nicola Manderson (FRACOL, DOL, OBA) <input type="checkbox"/> Dr Helen Spence (FRACOL, DOL, OBA)
Your doctor please specify (tick) specialist by selecting a consultant from above:	
Specialist: _____	D.O.B.: _____
Address: _____	Telephone: (02) _____
Does patient require an interpreter: <input type="checkbox"/> No <input type="checkbox"/> Yes Language spoken: _____	Indigenous Status: <input type="checkbox"/> Aboriginal / Torres Strait Islander <input type="checkbox"/> Other: _____
No. of pregnancies: _____ No. live births: _____ LMP / EDC: _____	EDS Score: _____ GDM: _____
<b>Current History &amp; Presenting Problem:</b>	
Gravida: _____ Para: _____ DOR (MUST be provided): _____ LMP (if known): _____	Confirm that all booking bloods and concurrent AN Care referral are attached to this referral: <input type="checkbox"/> Yes <input type="checkbox"/> No
Confirm that the woman has been provided with a request form for FTS bloods at 10-14 weeks: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Please specify: _____	
Additional relevant clinical history (e.g. maternal medical conditions, family history of genetic or structural issues): _____	
<b>Checklist of questions to be answered:</b>	
First trimester screening including structural assessment, screening for pre-eclampsia and FTS	
Pregnancy planning and education of pregnancy model of care	
Documentation Required (where appropriate):	
First trimester screening service appointment	
OR	
Initial pregnancy assessment (for women 13-14 weeks at presentation, women who have completed FTS with another provider or women seeking secondary screening)	