Te Whatu Ora
Health New Zealand
Waitaha Canterbury
MATERNITY SERVICES

Obstetric Clinic Referral

PATIENT DETAILS

SURNAME: .... NHI: ....
FIRST NAME: .... DOB: ....
ADDRESS: ....
.... POSTCODE: ....
(or affix patient label)

PHONE..
GP: ....
G: .... P: .... GEST: .... EDD: ……..../……..../………
Height: .... Weight: .... BMI: ....

☐ Maternity Booking form *if form has already been sent to CWH tick here* ☐	Relevant results: ☐ Scans (**Longhurst**) ☐ GROW ☐ Other

REASON FOR REFERRAL

(please provide additional details in Further Information/Comments section)

ANTENATAL	POSTNATAL	MEDICAL HISTORY
☐ Pregnancy induced hypertension (PIH) ☐ Small for gestational age/Fetal growth restriction (SGA/FGR) ☐ Oligo/Poly hydramnios ☐ Multiple pregnancy ☐ Malpresentation ☐ Antepartum haemorrhage (APH) ☐ Recurrent miscarriage (history of) ☐ Previous caesarean section VBAC referral: ☐ Yes ☐ No ☐ Other:	☐ .... **If fetal loss**, *tick box* ☐ Referral Guidelines Section 88: ☐ Primary care ☐ Consultation ☐ Transfer of care	☐ Endocrine/Diabetes ☐ Cardiac ☐ Haematology ☐ Neurology ☐ Respiratory ☐ Renal ☐ Autoimmune/Rheumatology ☐ Other:

FURTHER INFORMATION/COMMENTS

Type of appointment ☐ Face to face ☐ Phone ☐ Zoom (Telehealth)

LMC/REFERRER DETAILS

Name:	
Address:	
Telephone Mobile:	Home: ( )
Email:	
Signature:	Date: / /

Send via ERMs or email to maternity.clinic@cdhb.health.nz

OBSTETRIC CLINIC REFERRAL

C2401167