Capital & Coast District Health Board
ŪPOKO KI TE URU HAUORA

Patient Name Label
Surname:
First names:
NHI:

Fetal Medicine Service Referral

Please complete all the details so Fetal Medicine Team can process the referral promptly

Date of referral:	
Name & address of referrer: Contact phone no:	
LMC name & contact address: Contact phone no:	
GP name, address: Contact phone no:	
Patient address: Contact phone no: Home: Mobile:	
LMP: EDD (USS confirmed): Gravida: Para:	
Blood group:	1st Antenatal blood results attached: Yes ☐ No ☐
DOB:	Antenatal screening results attached: Yes ☐ No ☐
Date of last USS:	Last USS report enclosed Yes ☐ No ☐
Nuchal translucency (NT) scan performed Yes ☐ No ☐	
Result of NT scan:	
All USS reports attached Yes ☐ No ☐	
Reason for referral / provisional diagnosis:	
Referral discussed with: At Wellington Fetal Medicine Service Date:	
Has appointment been made already Yes ☐ No ☐	Appointment: Date: Time:

Fax completed form to: (04) 385 5311

From 0800-1630hrs – Referrals are prioritised daily by one of our fetal medicine consultants
For urgent communication – Contact Obstetrician on call via Hospital Switchboard
Or MFM Midwife Madeline Dymond-Cate, 0211998223 (Wellington Hospital)

For any **urgent or urgent out of hours** communication please contact the on call Obstetric Consultant, through the Wellington Hospital switchboard