Pre-Natal Testing Referral

Te Whatu Ora
Health New Zealand
Lakes

Date of Referral:		
Patient Name:	NHI:	Date of Birth:
Patient Address:	Patient Phone Mobile:	Patient Phone Home:
Referrer Name:	Referrer Email or Address:	Referrer Phone:
LMC Name:	LMC Email or Address:	LMC Phone:
GP Name:	GP Email or Address:	GP Phone:

LMP:	EDD (USS confirmed):	Gravida:	Parity:
Blood Group:		1st antenatal bloods attached: Yes ☐ No ☐	
Reason for referral/provisional diagnosis:			
Is this a multiple gestation? (twin/triplet) Yes ☐ No ☐			
Nuchal scan performed: Yes ☐ No ☐		NT report attached: Yes ☐ No ☐	
Antenatal screening (e.g. CFTS, MSS2, NIPS) report attached: Yes ☐ No ☐			
Referral discussed with:		Date discussed:	
Has appointment been made already: Yes ☐ No ☐		Appointment Date and Time:	

For urgent or out of hours communication please contact the On-call Obstetric Consult through Rotorua Hospital Switchboard P: (07) 348 1199

Email referral with supporting documentation to: **CLICK HERE to email referral**