Referral Form

Hampton Park
Women's Health Clinic
4 Warana Drive, Hampton Park Vic 3976
Ph: (03) 9799 2817 Fax: 9005 2834

Patient Details:

Patient Name: _____

Date of Birth: _____/_____/_____

Phone Number: H: _____ M: _____

Reason for Referral:

☐ Surgical Termination of Pregnancy ☐ Medical Termination of Pregnancy

☐ Contraception: ☐ IUD ☐ Implanon ☐ Depo-Provera

☐ Vasectomy

☐ Gynaecology: _____

☐ Fertility: _____

☐ Other: _____

Clinical Details:

LMNP: _____/_____/_____ Gestation: _____ Weeks

Blood Group: ☐ Yes _____ ☐ No

Copy of Pathology Results: ☐ Yes (fax to 03 9005 2834) ☐ No

Chlamydia PCR: ☐ Yes ☐ No

Pregnancy Test U BhCG: ☐ Yes ☐ No

Past Medical/Gynaecological History: _____

_____

Current Medications: _____

Allergies: _____

Referring Practitioner Details: