Hampton Park Women's Health Care

www.hpwh.com.au

Please tick for more pads ○

Referral Form

Patient details		
Name:	D.O.B	Phone:

My patient has requested assistance with (Please tick) ✓

○ **Termination of pregnancy**

LNMP: / / **Formal Ultrasound** performed on ___ /___ = ___ w ___ d

Formal Blood Group _____ **Rh** _____ (Please email: **tasmania@hpwh.com.au**)

Serum bhcg _____ Date ____ /____ /____

○ **Contraceptive Device Insertion** requested: Mirena / Copper 380 TT / Implamon

○ **IUD removal:** MIrena / Copper TT / Multiload / unknown. Inserted when? ___ /___ /___

Is the string present? Yes / No (f not lease send a copy of the formal ultrasound to inform us of the position of the IUD via **email**).

Patient BMI BMI 40 and under	Past medical History	Medication	Allergies

Referrer information:	
Name:	Provider Number:
Address:	Suburb:
Postcode:	Phone:
Email:	Date:

HDAA ACCREDITED ORGANISATION

NATA

ADHA Australian Day Hospital Association Member

NSQHS STANDARDS A better way to care