Peninsula Health
Women's Services

REFERRAL
FETAL DIAGNOSTIC SERVICE

UR NUMBER .....

SURNAME .....

GIVEN NAMES .....

DATE OF BIRTH .....
Please fill in if no Patient Label available

App.9/4/25 Print Code:17433

PHF35276 0v

Referral Date: ...../...../.....

Gestation@referral ☐

Referral to: *Dr. Nisha Khot*

Fetal Diagnostic Service
Women's Services Antenatal Clinic
Outpatient Area 1 Building D
Frankston Hospital
Phone: 9784 2600
Fax: 9125 9846
If Urgent Ring: 9784 2647

Referring Doctor:

Name: .....

Contact number *(mobile preferred)*: .....

Provider Number: .....

Signature: .....

Patient referral for:

☐ Fetal diagnostic invasive testing (indicate below)

☐ CVS ☐ Amniocentesis ☐ Fetal diagnostic ultrasound

Spoken Language: ..... Interpreter Required: ☐ Yes ☐ No

Pregnancy: LMP: ...../...../..... EDD: ...../...../..... Gravidity ..... Parity ..... BMI .....

Indication: ☐ Abnormal screening test ☐ High risk of genetic anomaly *(eg FH, previous affected baby)*

☐ Abnormal ultrasound finding ☐ Maternal infection ☐ PI accreta

☐ Vasa Praevia ☐ severe IUGR ☐ MCDA Twins

Aneuploidy screening: ☐ Declined ☐ NIPS ☐ FTCS ☐ T2MSS Result: .....

US reports: ☐ Yes ☐ No

Past Obstetric History: .....

.....

Prior Genetic Counselling: ☐ Yes ☐ No

Family History: .....

.....

Medical History / Drugs / Allergies: .....

.....

What counselling has been provided:

☐ Verbal ☐ Written Information ☐ Referred to Monash Genetics Services

GP Name & Practice Address (if not referred by GP)

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Ensure that the following are included in the referral:

☐ ultrasound reports
☐ antenatal screening test results
☐ blood group and antibody result

Office Use Only

Received: ...../...../.....

Triaged: ...../...../.....

Outcome: Accept / Reject
More information required

Ultrasound
Booked : ...../...../.....

ANC
Booked : ...../...../.....

Pt & Dr Notified: Phone / Mail

Date Notified: ...../...../.....

REFERRAL FETAL DIAGNOSTIC SERVICE

MR/352760

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