



Dr Simon Meagher
 Obstetrician, Gynaecologist, Ultrasonologist
 BSc MB BCh BAO FRCPI FRCOG FRANZCOG DDU COGU
 & ASSOCIATES

Patient Details

| | |
|---------|---------------|
| Name | Date of Birth |
| Address | Telephone (H) |
| | Telephone (B) |
| | Med. No. |

Request For:

Clinical Details:

Referring Doctor Details

Copies to:

Doctor Signature

Date

PREGNANCY ULTRASOUNDS

1ST TRIMESTER - PLEASE INDICATE WHERE APPLICABLE.

- | | | |
|--|--|--|
| <input type="checkbox"/> Uncertain dates | <input type="checkbox"/> Risk of miscarriage | <input type="checkbox"/> ?Ectopic |
| <input type="checkbox"/> Risk of fetal abnormality/Nuchal Translucency | | <input type="checkbox"/> Advanced maternal age |
| <input type="checkbox"/> Risk of fetal abnormality/Combined maternal serum & Nuchal Translucency screening | | <input type="checkbox"/> High risk pregnancy |

2ND TRIMESTER

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> 19-20 week anatomy scan | | |
| <input type="checkbox"/> Repeat 2nd trimester scan for: | <input type="checkbox"/> Incomplete anatomy | <input type="checkbox"/> ?Abnormality |

3RD TRIMESTER

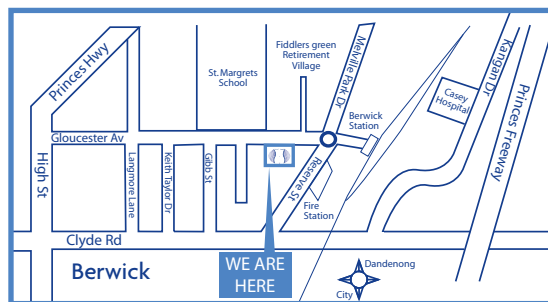
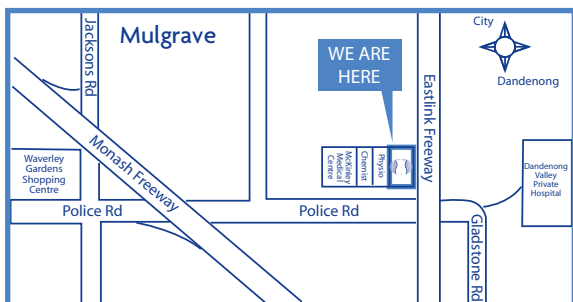
- | | | |
|---|---|--|
| <input type="checkbox"/> ?Fetal abnormality | <input type="checkbox"/> ?IUGR | <input type="checkbox"/> Prolonged pregnancy |
| <input type="checkbox"/> Decreased fetal mvts | <input type="checkbox"/> ?Malpresentation | <input type="checkbox"/> Multiple pregnancy |
| <input type="checkbox"/> ?Placental abnormality | <input type="checkbox"/> Other | |

PRENATAL GENETIC TESTS

- | | |
|--|--|
| <input type="checkbox"/> Amniocenteses with consultation | <input type="checkbox"/> Chorionic Villus Sampling with consultation |
|--|--|

GYNAECOLOGICAL SERVICES

- | | |
|---|--|
| <input type="checkbox"/> Pelvic U/S | <input type="checkbox"/> Pelvic U/S +/- cyst aspiration |
| <input type="checkbox"/> Pelvic U/S with consultation | <input type="checkbox"/> Pelvic U/S +/- saline sonohysterography |



Your medical software program should contain a Radiology Referral Template that matches this referral form

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 Tel: (03) 9790 1766 Fax: (03) 9701 0011

Suite 1/72 Gloucester Avenue, Berwick VIC 3806
 Tel: (03) 9707 0887 Fax: (03) 9707 5885

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ABN 91 074 204 247