Ultrasound Referral – Obstetrics and Gynaecology

NKC Medical Pty Ltd. (Dr. Natalie Kiesey-Calding)

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Patient details

Name .....

Address .....

Date of Birth ..... Medicare Number ..... Telephone Number .....

TESTS REQUIRED

Dating scan (0-12 weeks gestation) ☐

Nuchal translucency (11-14 weeks gestation) ☐

- ☐ **Hyperemesis Gravidarum**
- ☐ Hypertension
- ☐ Diabetes Mellitus
- ☐ Toxaemia of Pregnancy
- ☐ Liver or Renal disease
- ☐ Autoimmune disease
- ☐ Cardiac disease
- ☐ Alloimmunisation
- ☐ Maternal infection
- ☐ Inflammatory Bowel Disease
- ☐ Bowel Stoma
- ☐ Abdominal Wall Scarring
- ☐ Previous Spinal or Pelvic Trauma or Disease
- ☐ Drug Dependency
- ☐ Thrombophilia
- ☐ Significant Maternal Obesity
- ☐ **Advanced Maternal Age**
- ☐ Abdominal Pain or Mass
- ☐ Uncertain Dates
- ☐ High Risk Pregnancy
- ☐ Previous Post Dates Delivery
- ☐ Previous Caesarean Section
- ☐ Poor Obstetric History
- ☐ Suspicion of Ectopic Pregnancy
- ☐ Risk of Miscarriage
- ☐ Diminished Symptoms of Pregnancy
- ☐ Suspected or Known Cervical Incompetence
- ☐ Suspected or Known Uterine abnormality
- ☐ **Pregnancy after IVF**
- ☐ **Risk of Fetal Abnormality**
- ☐ Other .....

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Morphology scan (17-22 weeks gestation) ☐

Gynaecological scan of the pelvis ☐

Other ☐

Clinical details .....

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Growth scan (> 22 weeks gestation) ☐

Fetal well being (> 22 weeks gestation) ☐

- ☐ Known or suspected fetal abnormality or fetal cardiac arrhythmia
- ☐ **Fetal anatomy (late booking or incomplete mid-trimester scan)**
- ☐ Malpresentation
- ☐ Cervical assessment
- ☐ Clinical suspicion of amniotic fluid abnormality
- ☐ Previous complicated delivery
- ☐ Uterine scar assessment
- ☐ Uterine fibroid
- ☐ Previous fetal death in utero or neonatal death
- ☐ Antepartum Haemorrhage
- ☐ **Clinical suspicion of intrauterine growth retardation**
- ☐ **Clinical suspicion of macrosomia**
- ☐ Reduced fetal movements
- ☐ Suspected fetal death
- ☐ Abnormal cardiotocography
- ☐ Prolonged pregnancy
- ☐ Premature labour
- ☐ Fetal infection
- ☐ **Pregnancy after assisted reproduction**
- ☐ Trauma
- ☐ Diabetes Mellitus
- ☐ Hypertension
- ☐ Toxaemia of Pregnancy
- ☐ Liver or renal disease
- ☐ Autoimmune disease
- ☐ Cardiac disease
- ☐ Alloimmunisation
- ☐ Maternal infection
- ☐ Inflammatory Bowel Disease
- ☐ Bowel Stoma
- ☐ Abdominal wall scarring
- ☐ Previous spinal or pelvic trauma or disease
- ☐ Drug dependency
- ☐ Thrombophilia
- ☐ Significant maternal obesity
- ☐ Advanced maternal age
- ☐ Abdominal pain or mass

Clinical details

G _____ P _____ M _____ E _____ T _____

Previous scans? If yes, then weeks gestation ...../40 and estimated due date .....

Otherwise LNMP ..... and estimated due date .....

Specific clinical indications are required to facilitate booking and processing.

Referring doctor's name ..... Provider number .....

Date of referral. ..... Signature .....

Reports will be posted to the referring doctor unless otherwise arranged and the patient will also be given a copy.
If patients require a quote prior to the examination, please ask them to contact the reception staff at their convenience.