

ENDORSED MIDWIFE CARE REFERRAL FORM

*All referrals are to be emailed Attention: Endorsed Midwife Care to info@gatewayhealth.org.au

Referral Details

Referral Date			
Name of Referrer			
Clinic Name		Contact No.	
Clinic Address		Has the client consented to this referral?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Client Information

Full Name		Date of Birth	
Preferred Name		Contact No.	
Address		Language Spoken	
		Interpreter Needed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Usual Doctor (inc. Address & Contact)			

Reason for Referral

- | | |
|---|---|
| <input type="checkbox"/> Preconception health (Family Planning) | <input type="checkbox"/> Pregnancy care (Antenatal and Postnatal) |
| <input type="checkbox"/> Women's health care (Before, During and After Pregnancy) | <input type="checkbox"/> Other (Outline Below) |

Are there any Risk or Safety concerns for the Client? If yes, Detail Below (e.g. Family Violence, Mental Health) Yes No

Does the Client meet any Priority Criteria?

- | | | |
|---|---|--|
| <input type="checkbox"/> Aboriginal and/or Torres Strait Islander | <input type="checkbox"/> Recent Significant Event | <input type="checkbox"/> No other Supports available |
| <input type="checkbox"/> Disability | <input type="checkbox"/> Homelessness or Risk of | <input type="checkbox"/> No other Services involved |
| <input type="checkbox"/> Newly arrived Migrant or Refugee | <input type="checkbox"/> Healthcare Card | <input type="checkbox"/> Other (Outline Below) |

