Capital & Coast
District Health Board
ŪPOKO KI TE URU HAUORA

Send referral to Women's Clinics-Outpatients, Level 3 North, Wellington Hospital or
Fax: 04 806 0762
or Email to: RES-PrimCareRef@ccdhb.org.nz

Obstetric Anaesthetic referral and consultation form

Referral for consultation is preferred between 20 and 28 weeks gestation

Sticky label or
Patient Name:
NHI:
DOB:
Address:

Patient phone number(s) : ______________

: ______________

LMC: ______________________

G: **P:** **EDD:**

(Note: EDD aids in prioritizing appointments. Failure to record EDD may result in delays or referral being discarded.)

Interpreter required: ☐ **Yes** ☐ **No** **Language** ____________________

Planned mode of delivery (if known): ____________________

Reason for referral to anaesthetist (please tick box(es) and add relevant information):

☐ **Planned elective caesarean section** Reason: ………………………………………. Date if known: …………….

☐ **Previous problem with anaesthesia or pain relief in labour:** ____________________

☐**Obstetric difficulty e.g.** ☐**multiple pregnancy** ☐**placenta praevia** ☐**other** ____________________

☐ **Coagulation problem** ☐ **low platelets** ☐ **on anticoagulants** ☐ **Factor V Leiden** ☐ Other ______________

☐ **Back or spinal problem/surgery:**

☐**Neurological problem:**

☐ **Cardiology or heart problem:**

☐ **Allergy or drug reaction:**

☐**Specific anaesthesia risk:** ☐ **Malignant hyperthermia** ☐ **Plasmacholinesterase deficiency**

☐ **Obesity (>120kg):**

☐ **Women's request Wishes to discuss:** ______________________________

Urgency:

☐ **Immediate (please advise reason)** ________________________

(Please ring the on call anaesthetic consultant to discuss)

☐ **Urgent within 2-4 weeks**

☐ **Non urgent**

Name of referrer (legibly please) : ____________________ **Date:** ____________

If you wish to discuss this referral or are uncertain about timing or necessity, please contact bookings co-ordinator Ext. 80764 or the delivery suite anaesthetic consultant.