Prophylactic Anti-D Clinic Referral Form

Women's Health Service

The referral will not be processed unless all the information on this form is completed. Incomplete forms will be returned to the referrer for completion and re-referral.

Date referred:	Email:	
Woman's name:	NHI:	
Address:		
Contact phone no: Home:	Mobile:	Work:
Contact person:		
E-mail address:		
G: P:	LMP:	
Gestation at time of referral:	EDD:	By dates: ☐ By early scan: ☐
Reason for Prophylactic Anti-D administration		
PMH:		
Medications:		
Allergies (Describe any past reactions):		
Blood Group and Antibody status:	Included ☐	
LMC name: Contact details:		
Regular GP: Contact details:		
Please ask your woman to bring any hand held notes with them to the clinic appointment		

Email your referrals to: **RES-PrimCareRef@ccdhb.org.nz**