

## ENDORSED MIDWIFE CARE REFERRAL FORM

\*All referrals are to be emailed Attention: Endorsed Midwife Care to [info@gatewayhealth.org.au](mailto: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

### 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)       |

