

# Women & Children's Health Outpatient Department

Level 3 South Block, Nepean Hospital  
Cnr Derby and Somerset St, Kingswood NSW  
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## Health

Nepean Blue Mountains  
Local Health District

### Specialists available in this department:

<b>High Risk Antenatal Care</b>	<input type="checkbox"/> Dr Steven Joung	<input type="checkbox"/> Dr Olivia Byrnes	<input type="checkbox"/> Dr Vicki Chio	<input type="checkbox"/> Dr Maylene Pineda
<b>Low Risk Antenatal Care</b>	<input type="checkbox"/> Dr Dheya Al Mashat	<input type="checkbox"/> Dr Glenn Blanchette	<input type="checkbox"/> Dr Sarah Pixton	<input type="checkbox"/> Dr Trupti Kanade
<b>Gynaecology &amp; Colposcopy</b>	<input type="checkbox"/> Dr Dheya Al Mashat	<input type="checkbox"/> Dr Glenn Blanchette	<input type="checkbox"/> Dr Nicole Stamatopoulos	
	<input type="checkbox"/> Dr Kathleen Niven	<input type="checkbox"/> Dr Louise Wang	<input type="checkbox"/> Dr Nikhil Patravali	
<b>Paediatrics</b>	<input type="checkbox"/> Dr Vishal Gupta			
<b>Paediatric Surgery 2-16 yrs</b>	<input type="checkbox"/> Dr John Harvey			
<b>General Clinic</b>	<input type="checkbox"/> Antenatal	<input type="checkbox"/> Gynaecology	<input type="checkbox"/> Colposcopy	

### Patient Details

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Previous Surname/s: \_\_\_\_\_  
Medicare No.: \_\_\_\_\_ Parent/Carer Name: \_\_\_\_\_

### Current Pregnancy

LMP: \_\_\_\_\_ EDC: \_\_\_\_\_  
Gravida: \_\_\_\_\_ Para: \_\_\_\_\_  
Current pregnancy concerns: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Medical History

**URGENT**  
 Post coital bleeding  PV bleeding/uterine  
 Post-menopausal bleeding  Pelvic pain  
Other: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Significant Previous Obstetric History

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Presenting Problem

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Examination

BP: \_\_\_\_\_ at \_\_\_\_\_ week's gestation  
Weight: \_\_\_\_\_ Height: \_\_\_\_\_ BMI: \_\_\_\_\_  
Other findings: \_\_\_\_\_

### Last Cervical Screening Test \_\_\_ / \_\_\_ / \_\_\_

Risk Category: \_\_\_\_\_  
HPV: \_\_\_\_\_  
LBC: \_\_\_\_\_

### Referring Doctor

Name/Provider Number \_\_\_\_\_  
Practice: \_\_\_\_\_  
Date \_\_\_\_\_ Signature \_\_\_\_\_

### Medications/Investigations

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please attach copies of relevant pathology and scanning to this referral**