



Christopher Kohlenberg Department of Perinatal Ultrasound

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MRN
FAMILY NAME
GIVEN NAME
DOB: _____ Ph: _____
ADDRESS
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Appointment Date: _____ Time: _____

Referral for Consultation

Dear Dr

Thank you for consulting the following patient in conjunction with a requested scan: (please tick)

Counselling re scan findings		MFM opinion	
Ultrasound procedure		Management plan	

EDC:

Clinical information:

Request for Imaging

PREGNANCY SCANS (Please tick)		TARGETED	
DATING SCAN		PRENATAL DIAGNOSIS (Amnio/CVS)	
FIRST TRIMESTER ANATOMY SURVEY +/- SCREENING		CERVICAL SURVEILLANCE	
Aneuploidy screening		SGA/IUGR SURVEILLANCE	
Preeclampsia screening		REVIEW OF SUSPECTED FETAL ANOMALY	
MIDTRIMESTER MORPHOLOGY SCAN		CARDIAC SCAN	
FETAL WELLBEING +/- GROWTH		NEUROSONOGRAPHY	
POSTDATES		FETAL PROCEDURE	
GYNAECOLOGY SCANS			
PELVIC SCAN		Hysterosalpingo Contrast Sonography	
ENDOMETRIOSIS SCAN with bowel prep		SALINE sonography	
MIRENA insertion/removal		OTHER:	

Referral Information

Referring Doctor:

Name/Provider Number:

Practice/Position:

Date:

Signature:

Phone:

Email:

Patient location:

Ward:

NBMA-221b 20250930

Patient Referral, Perinatal Ultrasound

Nepean Blue Mountains Local Health District

Patient information

Appointment instructions:

- Please bring your Medicare Card and referral.
- One support person may attend your scan.
- It is not recommended that young children attend the scan as they may distract the sonographer/doctor performing the examination. This could affect the scan quality and accuracy.
- If you are more than 20 minutes late for your appointment it may be rescheduled.

