



### PATIENT INFORMATION

NAME ..... AKA .....

D.O.B ..... N.H.I. ....

TELEPHONE NUMBER ..... MOBILE NUMBER .....

NZ RESIDENT: YES NO NATIONALITY.....

LANGUAGE SPOKEN .....

*N.B. IF THE PATIENT'S ENGLISH LANGUAGE IS INSUFFICIENT TO COMPLETE INFORMED CONSENT, A TRANSLATOR WHO IS FLUENT IN BOTH ENGLISH AND THE PATIENT'S OWN LANGUAGE WILL BE REQUIRED TO ACCOMPANY THEM. PARTNERS AND FAMILY MEMBERS ARE NOT DEEMED TO BE IMPARTIAL TRANSLATORS.*

APPOINTMENT DATE ..... APPOINTMENT TIME .....

LMP DATE ..... SCAN DATE AND RESULT .....

### RELEVANT MEDICAL/SOCIAL/OBSTETRIC/SOCIAL HISTORY

TESTS REQUIRED	DATE TAKEN	TESTS REQUIRED	DATE TAKEN
1ST ANTENATAL BLOODS	.....	ULTRASOUND	.....
CHLAMYDIA, HVS, ECS	.....	SMEAR (IF DUE)	.....

### REFERRING DOCTOR'S DETAILS

DOCTOR'S NAME ..... SIGNATURE .....

ADDRESS .....

PHONE ..... FAX .....