Midwifery Resource Centre

RAADP REFERRAL

PERSONAL INFORMATION

Date : _____

Full Name :
(PLEASE USE CAPITAL)

Date Of Birth : _____ / _____ / _____ **NHI:** _____

Address : _____

Phone Number : _____ **E-Mail** : _____

Ethnicity : _____ **EDB** : _____

Gestation at time of referral : _____

Information pack given : Yes ☐ No ☐

Booking bloods completed : Yes ☐ No ☐

Subsequent antenatal blood form given : Yes ☐ No ☐

Pregnant person aware bloods to be done 3 days prior to 28 week appt. : Yes ☐ No ☐

REFERRER CONTACT DETAILS

Name : _____ **Email address** : _____

Designation : _____ **Mobile Number** : _____

OFFICE USE ONLY

Date recieved : _____

28 week booking : _____ **Staff name** : _____

35 week booking : _____ **Staff Signature** : _____

Contact information

376 Manchester Street, Christchurch

026 682 7555

midwiferyresourcecentre.org

services@midwiferyresourcecentre.org

THANK YOU

CONSENT FOR USE OF BLOOD PRODUCTS

Affix patient label here

I _____ *(Medical Officer/Midwife giving information to patient)* have given and explained information in relation to the administration of blood components/blood products to _____ *(Person receiving the information).*

This information included:

- The purpose of giving blood components or blood products to this patient;
- The type of blood, blood components or blood products to be used;
- The risks associated with their use;
- Available alternatives to the use of blood and blood products

I have also offered the patient the opportunity to ask questions and where questions have been asked I have answered them appropriately and to the best of my ability.

_____	_____	_____
Signature (Medical Officer)	**Designation**	**Date**

PATIENT CONSENT

If there is anything that you don't understand about the explanation or if you want more information, please ask before signing this form.

I _____ *(name of person giving consent)* have been provided with sufficient information in relation to the administration of blood components/blood products. I have been given the opportunity to ask questions and my questions have been satisfactorily answered.

I consent to the administration of _____ *(type of blood/blood product to be used).* I also consent to any further alternative measures or treatments as may be found necessary during the use of these products.

I give this consent for myself/for _____ who is my _____

_____	_____
Signature (Person giving consent)	**Date**

NOTE: This consent is for the total number of blood products administered for the ongoing management of a particular disease, disorder or pregnancy.

Day Stay CDHB Medication Chart

Chart ____ of ____

First prescriber to write patient's name and NHI:

Family Name: _____

Given Name: _____ Gender: _____

AFFIX PATIENT LABEL HERE

Date of Birth: _____ NHI#: _____

Allergies & Adverse Reactions

No ☐

Medication / other	Reaction	New this admission	Medication / other	Reaction	New this admission
		☐			☐
		☐			☐
		☐			☐
		☐			☐
		☐			☐

Signature _____ Date _____

Special Care Required No ☐

- ☐ Renal impairment
- ☐ Hepatic impairment
- ☐ Pregnancy
- ☐ Breastfeeding
- ☐ Anticoagulation
- ☐ Other _____

Once Only (Verbal Orders: follow local policy when recording)

Date	Medicine	Dose	Units	Route	Dose calculation (eg. mg/kg per dose)	Prescriber's signature	Date administered	Given by
					Date & time of dose	Pharmacy & special instructions / Pharm	Time commenced / Time completed	Checked by

Sample signatures – Prescribers

Name & Reg No. (family & given)	Signature	Contact No.

Sample initials – Administrators/Others

Name & Reg No. (family & given)	Initials

DAY STAY