



Referral Form

Early Pregnancy Clinic

Complete ALL the following information, including requested supporting documentation listed below, and fax to 416-586-5941. Appointments will NOT be given until ALL required information is received. Once all required documentation is received, the clinic will call the patient with appointment details.

Patient Information

Name: _____ Phone: _____
(Last Name) (First Name)

Date of Birth: _____ Health Card No.: _____ VC: _____
(DD-MM-YYYY)

Address: _____

LMP: (date of last menstrual period): _____
(DD-MM-YYYY)

Gravida	Para	Spontaneous Abortion	Therapeutic Abortion	Ectopic
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Does patient need a translator? No Yes If yes, specify language _____

Previously seen in Women's Unit? No Yes If yes, specify year(s) _____

Please check off any that apply:

- Vaginal Bleeding Abdominal Pain/Cramping Severe Vomiting

Specific Concerns: (please explain):

To process this referral, the following documentation is required:

- Recent Ultrasound Beta hCG result Blood Group & Screen

Referring Physician

Name: _____ Phone: _____
(Last Name) (First Name)

Address: _____ Fax: _____

Email: _____ OHIP Billing No. _____

Early Pregnancy Clinic Use Only

Patient called for appt: No Yes Date of Call: _____ Appt. Date/Time _____ .