Referral
Recurrent Pregnancy Loss clinic
BC Women's Hospital
Phone: (604) 875-3706
Fax: (604) 875-3136

BC WOMEN'S HOSPITAL+ HEALTH CENTRE
An agency of the Provincial Health Services Authority

Appointment will be given directly to the patient

Woman's Name *(first and last)*

Phone Number
Home Work Cell

Address

City/ Town & Postal Code

Date of Birth *(day/month/year)*

MSP/ PHN

Referring Caregiver name: ____________________

Phone: ____________________

Fax: ____________________

Billing # ____________________

cc other Caregiver – name: ____________________

Out of country/province ☐ No ☐ Yes
Language Spoken____________________________

Language barrier ☐ No ☐ Yes
Interpreter required ☐ No ☐ Yes

Pregnancy History
G_____ T_____ P______ SA_____ TA _______E _____ L______

Reason For Referral
☐ at least 2 consecutive miscarriages
(must be > 6 weeks gestation)
☐ 1 miscarriage > 10 weeks by U/S size

*Patients will be assigned to the **first available** physician unless specified*:

Bloomenthal ☐
Bedaiwy ☐
Racette ☐
Williams ☐

☐ **Other referrals:**
____
____
____
____

Send a copies of the following if available:
☐ Laboratory results
☐ Blood Type
☐ Ultrasounds
☐ Consultation(s)

Key
G = Gravid
T = Term
P = Premature
SA = Spontaneous Abortion
TA = Therapeutic Abortion
E = Ectopic
L = Living

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