

Early Pregnancy Assessment Clinic

BC Women's Hospital
 Phone (604) 875-2592
 Fax (604) 875-3136

**Appointment will be given directly to the patient**

Date: _____

Name		Pronouns	Referral from: <input type="checkbox"/> BCW Urgent Care Centre <input type="checkbox"/> FP/ Midwife/ NP Office <input type="checkbox"/> OB/GYN Office <input type="checkbox"/> Self-referral <input type="checkbox"/> ED <input type="checkbox"/> Fertility Centre <input type="checkbox"/> Other _____
DOB		PHN	
Address			
City & Postal Code			
Email	Consent to Email <input type="checkbox"/> No <input type="checkbox"/> Yes		Referring provider name: _____ Billing # : _____ cc: _____ cc: _____
Phone Number			
Primary		Alternate	
Identify as Indigenous	<input type="checkbox"/> No <input type="checkbox"/> Yes	Interpreter required <input type="checkbox"/> No <input type="checkbox"/> Yes	
Valid MSP	<input type="checkbox"/> No <input type="checkbox"/> Yes	Interpreter booked <input type="checkbox"/> No <input type="checkbox"/> Yes	
Private pay	<input type="checkbox"/> No <input type="checkbox"/> Yes	Language spoken _____	

Please note that:

- A large number of losses are due to **random aneuploidy** (abnormal number of chromosomes) in the embryo.
 - We recommend **cytogenetic testing** at the time of 2nd and subsequent pregnancy losses
 - Self-collection** of pregnancy tissue for cytogenetic testing is possible in the setting of spontaneous miscarriage or medical management of miscarriage. For process and form, see *EPAC website for more information on this*.
 - Medical management with **Mifegymiso** has been shown to be highly effective. For protocol, see *EPAC website*.
- * Patients with a known demise desiring surgical management should have this form faxed *
 to the CARE program (604) 875-3274, and advised to contact the clinic at (604) 875-2022**

Pregnancy History

G_____T_____P_____SA_____TA_____E_____L_____

Ultrasound (if done):

Date: _____

LMP: Day_____Month_____Year_____

Facility: _____

Gestational Age: _____ ☐ By LMP ☐ By Ultrasound

Gestational Age: _____

Reason for referral:

- ☐ Cramping or spotting ≥ 6 wks and $\leq 12+6$ wks
- ☐ Pregnancy of unknown viability
- ☐ Pregnancy of unknown location
- ☐ Known demise $\leq 12+6$ wks by U/S, management undecided
- ☐ Other: _____

Notes:

Done	Not Done	Send copies of the following if available:
<input type="checkbox"/>	<input type="checkbox"/>	Consultation(s)
<input type="checkbox"/>	<input type="checkbox"/>	Blood Type
<input type="checkbox"/>	<input type="checkbox"/>	HCG levels
<input type="checkbox"/>	<input type="checkbox"/>	Ultrasounds
<input type="checkbox"/>	<input type="checkbox"/>	Laboratory results

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