

**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:		<b>Referral from:</b> <input type="checkbox"/> BCW Urgent Care Centre <input type="checkbox"/> GP/ 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		<b>Referring provider name:</b> _____ Billing #: _____ cc: _____ cc: _____	
Phone Number			
Primary	Alternate		
Out of country/province	<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 2nd consecutive pregnancy loss or any loss ≥ 10 weeks (byCRL).
  - **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\_\_\_\_\_

LMP: Day\_\_\_\_\_Month\_\_\_\_\_Year\_\_\_\_\_

Gestational Age: \_\_\_\_\_  By LMP  By Ultrasound

**Ultrasound (if done):**

Date: \_\_\_\_\_

Facility: \_\_\_\_\_

Gestational Age: \_\_\_\_\_

**Reason for referral:**

- Cramping or spotting ≥6wks and ≤12+6wks
- Pregnancy of unknown viability
- Pregnancy of unknown location
- Known demise ≤12+6wks 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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