

# Early Pregnancy Assessment Clinic

BC Women's Hospital  
 Phone (604) 875-2592  
 Fax (778) 504-9761



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

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

Name	Pronouns	<b>Referral from:</b> <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	<b>Referring provider name:</b> _____ <b>Billing # :</b> _____ CC: _____ CC: _____	
	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Phone Number	Alternate		
Primary			
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**

<b>Pregnancy History</b>	<b>Ultrasound (if done):</b>
G _____ T _____ P _____ SA _____ TA _____ E _____ L _____	Date: _____
LMP: Day _____ Month _____ Year _____	Facility: _____
Gestational Age: _____ <input type="checkbox"/> By LMP <input type="checkbox"/> By Ultrasound	Gestational Age: _____

<b>Reason for referral:</b>	<b>Notes:</b>
<input type="checkbox"/> Cramping or spotting ≥6wks & ≤12+6wks <input type="checkbox"/> Pregnancy of unknown viability ≥6wks & ≤12+6wks <input type="checkbox"/> Pregnancy of unknown location ≥6wks & ≤12+6wks BHCG ≤ 1500mIU/ml <input type="checkbox"/> Known demise ≤12+6wks by U/S, management undecided <input type="checkbox"/> Other: _____	_____ _____ _____ _____ _____

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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