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

BC WOMEN'S HOSPITAL+ HEALTH CENTRE
Provincial Health Services Authority

Appointment will be given directly to the patient

Date: _____

Name		Pronouns			
DOB		PHN			
Address					
City & Postal Code					
Email		Consent to Email	☐ No	☐ Yes	
Phone Number Primary		Alternate			
Identify as Indigenous	☐ No ☐ Yes	Interpreter required	☐ No	☐ Yes	
Valid MSP	☐ No ☐ Yes	Interpreter booked	☐ No	☐ Yes	
Private pay	☐ No ☐ Yes	Language spoken	_____		

Referral from:
- ☐ BCW Urgent Care Centre FP/
- ☐ Midwife/ NP Office OB/GYN
- ☐ Office
- ☐ Self-referral ED
- ☐ Fertility Centre
- ☐ Other _____

Referring provider name:
_____
Billing # : _____
Fax #: _____
cc: _____
cc: _____

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 a spontaneous or medically managed early pregnancy loss. 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 confirmed early pregnancy loss *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 & ≤10+6wks*
- ☐ Pregnancy of unknown viability *≥6wks & ≤10+6wks*
- ☐ Pregnancy of unknown location *≥6wks & ≤10+6wks and B H CG ≤ 1500mlU/ml*
- ☐ Early pregnancy loss ≤12+6wks by U/S, management undecided
- ☐ Other: _____

Notes:
_____
_____
_____
_____
_____

Done	Not Done	Send copies of the following, *if not available in CST*:
☐	☐	Consultation(s)
☐	☐	Blood Type
☐	☐	HCG levels
☐	☐	Ultrasounds
☐	☐	Laboratory results