

Appointment will be given directly to the patient

Date: _____

Name	Pronouns	<input type="checkbox"/> New patient <input type="checkbox"/> Re-referral. Reason: _____
DOB	PHN	
Address		Referring Provider name: _____ Billing #: _____
City & Postal Code		cc: _____
Email	Consent to Email	<input type="checkbox"/> No <input type="checkbox"/> Yes
Phone Number		
Primary	Alternate	cc: _____
Pregnancy History G ____ T ____ P ____ SA ____ TA ____ E ____ L ____		cc: _____
Identify as Indigenous <input type="checkbox"/> No <input type="checkbox"/> Yes Language barrier		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 loss.
- **Unexplained pregnancy loss refers to a pregnancy proven to be 46XX /46XY or where karyotype was not obtained.**

Reason for Referral

<input type="checkbox"/>	≥ 2 unexplained pregnancy losses at ≤10 weeks gestation (Biochemical losses must be > 6wks by LMP)
<input type="checkbox"/>	≥ 1 unexplained pregnancy loss ≥ 10 weeks and ≤ 20wks gestation by U/S
<input type="checkbox"/>	Patients with ≥ 1 documented unexplained pregnancy loss at any gestational age WITH:
<input type="checkbox"/>	Chronic histiocytic intervillositis OR
<input type="checkbox"/>	Known anti-phospholipid syndrome OR
<input type="checkbox"/>	Suspected major uterine anomaly (<i>includes fibroids, excludes arcuate uterus</i>) OR
<input type="checkbox"/>	Known parental translocation

Done	Not Done	Send copies of the following if available:
<input type="checkbox"/>	<input type="checkbox"/>	Consultation with summary of each pregnancy
<input type="checkbox"/>	<input type="checkbox"/>	Ultrasounds with confirmation of pregnancy
<input type="checkbox"/>	<input type="checkbox"/>	Ultrasounds with confirmation of demise
<input type="checkbox"/>	<input type="checkbox"/>	HCG levels if pregnancy not seen in ultrasound (pregnancy of unknown location)
<input type="checkbox"/>	<input type="checkbox"/>	Blood type
<input type="checkbox"/>	<input type="checkbox"/>	Surgical Pathology
<input type="checkbox"/>	<input type="checkbox"/>	Karyotype of the loss (If pending, referral is declined and re-referral is required once criteria met)
<input type="checkbox"/>	<input type="checkbox"/>	HSG or hysteroscopy or other anatomic evaluation
<input type="checkbox"/>	<input type="checkbox"/>	Parental karyotypes
<input type="checkbox"/>	<input type="checkbox"/>	TSH, Prolactin, HbA1C
<input type="checkbox"/>	<input type="checkbox"/>	Anti-cardiolipin antibody, Lupus Anticoagulant antibody, B-2 Glycoprotein antibody
<input type="checkbox"/>	<input type="checkbox"/>	Other: _____

Please note:

*Patients that are currently pregnant, have secondary infertility, seeking surgical correction without loss, or are undergoing Assisted Reproductive Technology will no longer be accepted as new referrals.

*We are unable to provide early Pregnancy Monitoring for patients living outside of the Lower Mainland. Referring Providers will be responsible for monitoring their patients with advice available from the RPL clinic.

Incomplete Referrals will not be accepted