

**Referral**  
**Recurrent Pregnancy Loss Clinic**  
 BC Women's Hospital  
 Phone: (604) 875-3706  
 Fax: (778) 504-9762

**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	<b>Referring Provider name:</b> _____  Billing # : _____  cc: _____  cc: _____  cc: _____	
City & Postal Code		
Email		
Phone Number Primary	Alternate	
Pregnancy History G____ T____ P____ SA____ TA____ E____ L____		
Identify as Indigenous <input type="checkbox"/> No <input type="checkbox"/> Yes    Language barrier <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 loss.
- **Unexplained pregnancy loss refers to a pregnancy proven to be 46XX /46XY or where karyotype was not obtained.**

**Reason for Referral**

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