

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	Referral from: <input type="checkbox"/> BCW Urgent Care Centre FP/ <input type="checkbox"/> Midwife/ NP Office OB/GYN <input type="checkbox"/> Office <input type="checkbox"/> Self-referral ED <input type="checkbox"/> Fertility Centre <input type="checkbox"/> Other _____ <input type="checkbox"/>	
DOB		PHN		
Address				
City & Postal Code				
Email		Consent to Email <input type="checkbox"/> No <input type="checkbox"/> Yes		Referring provider name: _____ Billing # : _____ CC: _____ CC: _____
Phone Number		Alternate		
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 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 HCG ≤ 1500mIU/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:
<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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