WRHN
Waterloo Regional Health Network

Patient Label

WRHN External Abortion Clinic Referral Form

Patient Name:_____ **Date of Referral:** _____

Date of Birth: _____ **LMP:**_____ **Gestational Age:** _____

Date of Misoprostol: _____ **Date of additional Misoprostol dose (if applicable):** _____

Prescribing Physician:_____

Patient:_____ has been assessed and examined by

(Physician): _____, who confirms that this patient is clinically stable in terms of bleeding and vital signs and is a suitable candidate to wait for procedural management of their retained products of conception (RPOC) at WRHN Procedural Abortion Clinic,

☐ the patient has been thoroughly counselled regarding the various options for RPOC including expectant management, medical management and Procedural management, and the patient wishes to pursue surgical management of the RPOC through this program.

☐ the patient has been informed that the decision to proceed with a surgical intervention is at the discretion of the WRHN Procedural Abortion Clinic Physician.

☐ the **referring** physician agrees to assume post procedure care and review of pathology with the patient.

The following results must be sent in order for the patient to be eligible for booking. All referrals, which are incomplete, will be declined and faxed back to the referring physician.

☐ CBC

☐ BHCG (Quant)

☐ ABO If RH negative, was Rhogam given? ☐ Yes ☐ No

☐ Ultrasound Report

Labs are preferred to be done as close to the time of the procedure as possible.

☐ Please fax completed form and above documents to: **519-749-4298**

☐ Please advise your patient to call the clinic at **519-749-4254** to book their appointment. It is the patient / referring physician's responsibility to call and arrange for an appointment. It is recommended that patients/referring providers call as soon as possible (once the required tests results are sent to the program along with this form) to facilitate an appointment.

Referring Physician: _____**License #:** _____

Physician Signature: _____