Humber River Health

Maternal & Child Program

EARLY PREGNANCY CLINIC REFERRAL FORM

*The **Early Pregnancy Clinic** provides urgent assessment of women **less than 13** weeks of pregnancy who have:*

- Bleeding or Spotting
- Missed Miscarriage
- Ectopic Pregnancy
- Spontaneous Miscarriage
- Incomplete Miscarriage
- Abdominal Pain

Note: This Clinic will not perform termination – Refer to Primary Care provider for Termination Consult.

To be completed by Emergency Department Physician/Nurse

Patient's Name: _____

Referring Doctor: _____ , MD

Reason for Referral/Follow-up: _____

_____

Phone #: _____ Fax#: _____

1. FAX this form along with copy of ED Chart to ext. (416) 242-1137

2. Please provide a copy of this form to the patient.

3. Please verify patient blood type and give RhIG if indicated.

4. Please send BHCG, Group and screen ultrasound results.

PATIENTS INSTRUCTIONS:

You are booked to receive follow-up medical care at the **Early Pregnancy Clinic** located on the 4th floor. Maternal & Child Program (*central elevator*.) Phone: (416) 242-1000 ext. 21450.

Please come to the **Early Pregnancy Clinic** between 08:00 and 10:00 on the day of your appointment. Your Clinic appointment is scheduled for: DATE: _____ TIME: _____

EARLY PREGNANCY CLINIC

Fourth Floor, Maternal & Child program (close to the CENTRAL elevator)

Monday – Wednesday – Friday 08:00 – 10:00 hours

Phone: (416) 242-1000 ext. 21450 **Fax** (416) 242-1137