Everywoman's Health Centre

REFERRAL FORM

Service requested: ❑ surgical abortion ❑ miscarriage management ❑ IUD insertion* ❑ IUD removal

Urgency: ❑ non-urgent ❑ urgent (includes [but not limited to] copper IUD insertion as emergency contraception)

CLIENT INFORMATION

Name: ..... Birth date: .....
(As on CareCard) Surname (in caps) First name Day Month Year

PHN/Health Care No.: ..... Telephone: .....
Cell Home/work

Address: .....
Unit number Street City Postal code

E-mail address: ..... Please check one: ❑ Patient will contact us herself *or*
❑ EWHC should contact this patient directly

Contraindications (for abortion/miscarriage management only):

❑ BMI ≥38

❑ Bleeding/clotting disorder

❑ Uncontrolled asthma

❑ Gestational age ≥ 13 weeks 6 days

❑ Other .....

.....

.....

Investigations: .....
Please list and attach copies of relevant ultrasound reports and blood tests.

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REFERRING PHYSICIAN INFORMATION

Name: ..... MSC #: .....
Surname (in caps) First name

Address: .....
Unit number Street City Postal code

Telephone: ..... Extension # ..... Fax: .....

....
Signature of referring physician ***Date of referral***

*Please have your client phone us as soon as possible if she requires an IUD for emergency contraception.

Please fax this form to 604-322-6632. Thank you!

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