

EARLY PREGNANCY ASSESSMENT UNIT
REFERRAL FORM

PATIENT LABEL

REFERRING CLINIC / PROVIDER LABEL

REASON FOR REFERRAL (select all that apply)

- | | |
|--|--|
| ☐ Vaginal bleeding | ☐ Uncertain viability |
| ☐ Pelvic/abdominal pain | ☐ Suspected or confirmed pregnancy loss |
| ☐ Pregnancy of unknown location | ☐ Other (please specify): _____ |

INVESTIGATIONS (if available)

β-hCG: Date: _____ Result: _____ Date: _____ Result: _____

Blood group/Rh: _____

Ultrasound: ☐ Done ☐ Not done ☐ Report attached

ADDITIONAL INFORMATION (optional)

IMPORTANT: NOT FOR EMERGENCY REFERRALS

The Early Pregnancy Assessment Unit is for clinically stable patients.

Patients who are hemodynamically unstable, have syncope, severe abdominal pain, significant hemorrhage, or suspected ectopic pregnancy should be sent to the Emergency Department.