CHILDREN'S & WOMEN'S HEALTH CENTRE OF BRITISH COLUMBIA
AN AGENCY OF THE PROVINCIAL HEALTH SERVICES AUTHORITY

Referral To
Early Pregnancy Assessment Clinic

BC Women's Hospital
Office: (604) 875 - 2592
Fax: (604) 875 - 3136
Appointment will be given directly to the woman.
REFFERAL WILL NOT BE PROCESSED IF FORM INCOMPLETE

Date of referral: D___ M ___ Y _____

Woman's Name *(first and last)*

Phone Number
Home Work Cell

Address

City/ Town & Postal Code

Date of Birth *(day/month/year)*

MSP/ PHN

Referral from:
☐ BCW Assessment Room
☐ Physician/ Midwife's Office
☐ Self Referral
☐ Other

Referring Caregiver name:
_____
Phone:_____
Fax: _____
Billing # _____
Primary Caregiver – name:
_____

Language Spoken_____
Language barrier ☐ No ☐ Yes

Interpreter required ☐ No ☐ Yes
Interpreter booked ☐ No ☐ Yes
Reference number:

Pregnancy History
G_____ T_____ P_____ SA_____ TA _____E _____ L _____
Last Menstrual Period: Day_____Month_____Year_____
Gestational Age: _____ ☐ By LMP ☐ By Ultrasound

Ultrasound (if done):
Date: _____
Facility _____
Gestational Age

Reason For Referral
☐ Cramping, spotting in 1st Trimester
☐ Known fetal demise
☐ Other

Notes:
_____
_____

For admission to the Early Pregnancy Assessment Clinic:
Send a copy of the following Lab Reports if available:
☐ Beta HCG
☐ Blood Type
☐ Ultrasounds

Key
G = Gravid
T = Term
P = Premature
SA = Spontaneous Abortion
TA = Therapeutic Abortion
E = Ectopic
L = Living

BCW # Created July 2007

Effective Date New 2007
Draft cm gd Aug. 30, 2007