William Osler Health System

Early Pregnancy Clinic

REFERRAL FORM

Patient Identification

◯ **Peel Memorial Centre for Integrated Health and Wellness**
20 Lynch St, Brampton, ON L6W 2Z8
Phone: 905-863-2552
Fax: 905-863-2524

◯ **Brampton Civic Hospital (ECTOPIC ONLY)**
Third Floor, Snow Elevator
2100 Bovaird Dr. East, Brampton, ON L6R 3J7
Phone: 905-494-6790
Fax: 905-863-2524

Service Information

Referral Source ☐ Emergency Department/ UCC ☐ OB/GYN ☐ Primary Health Care ☐ Other _____

The purpose of the Early Pregnancy Clinic is to provide timely assessment of women who are under 13 weeks gestation and experiencing complications in pregnancy (Please note: This clinic is **not for Therapeutic Abortion** nor its complications). The clinic hours are Monday to Friday from 08:00 - 12:00, and response time will be 48-72 hours (during work week).

Reason for Early Pregnancy Clinic Referral

Under 13 weeks gestation, in stable condition with any of the following:

- ☐ Bleeding/spotting
- ☐ Incomplete miscarriage
- ☐ Missed miscarriage
- ☐ Ectopic pregnancy **(stable, follow-up only after Gyaecology consult)**

Under 13 weeks gestation and Ultrasound showing a **viable pregnancy** consider the following after reassuring the patient:

- ☐ Refer back to her own family doctor or obstetrician
- ☐ Refer to PMC Maternity Care Clinic
- ☐ Refer to one of the Primary Care Obstetrics Physicians' offices directly: www.williamoslerhs.ca/pcob
- ☐ Refer to the office of the obstetrician & gynaecologist on-call

Patient Information

Patient's Last Name: _____ **Patient's First Name:** _____

Date of Birth: (DD/MM/YY) _____ **Gender:** ◯ Male ◯ Female ◯ Other

Health Card Number: _____ **Version:** _____ **No OHIP:** ☐

Address: _____ **City:** _____ **Province:** _____ **Postal Code:** _____

Phone # (primary): _____ **Phone # (alternate):** _____ **Cell #:** _____

Patient's E-mail: _____ ☐ **Interpretation Services Required; Language:** _____

Person to contact for booking appointment *(If different than patient):* _____

Relationship to patient: _____

Reason for Referral & Relevant Patient History

History of Presenting Complaint: _____

_____

Please attach the following documents: ☐ Beta-HCG ☐ Blood group ☐ CBC ☐ ER record
☐ Recent Ultrasound **at WOHS** and any outside or bedside ultrasounds

Did the patient receive Rhogam in ER? ◯ Yes ◯ No ◯ Not indicated

Please fax referral and any relevant lab tests and ultrasounds to 905-863-2524.

All patients will be booked by the Early Pregnancy Clinic, and the patient will be contacted directly.

Referring Clinician Information

Referring Clinician Name: _____ **OHIP Billing Number:** _____

Phone #: _____ **Fax #:** _____ **E-mail:** _____

Family Physician *(If different from above)*: _____

Signature of Referring Clinician: _____ **Referral Date:** _____

Clinic Use Only

Date Referral Screened: _____
Date Appt. Booked: _____
Date of Appt.: _____

Referral Received Actions:

- ☐ Approved
- ☐ Patient Declined
- ☐ Redirected to _____
- ☐ Other _____