Medical Termination of pregnancy service

Referring clinician details

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tel No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient details

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tel No : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medicare Card No:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Concession/Health care card No:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Interpreter required: Y/N

Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Checklist prior to referring (please tick) – The following information must be provided or else the referral may be returned:**

* Ultrasound scan report
* Blood group and antibody result
* FBC and iron studies
* Quantitative beta-HCG level
* Urine PCR for chlamydia and gonorrhoea

Signature of referring doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_