



**Reproductive Options and Services (ROSE) Clinic  
REFERRAL FORM**

Telephone: 902-473-2362

Fax: 902-473-8468

Date (YYYY/MON/DD): \_\_\_\_\_

**Medical Abortion**

**Surgical Abortion**

**Undecided**

Name: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
Last First Middle

HCN: \_\_\_\_\_ Expiry: \_\_\_\_\_ DOB (YYYY/MON/DD): \_\_\_\_\_

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

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Voicemail?  Y  N Other Phone: \_\_\_\_\_ Voicemail?  Y  N

Interpretation services required?  Yes  No Language: \_\_\_\_\_

**Gynecological History**

Gravida (G) \_\_\_\_\_ Paragravida (P) \_\_\_\_\_ Therapeutic Abortion (TA) \_\_\_\_\_ Spontaneous Abortion (SA) \_\_\_\_\_

Previous ectopic/tubal pregnancy?  Yes  No

Cesarean section #: \_\_\_\_\_ Dates (YYYY/MON/DD): \_\_\_\_\_

Vaginal delivery #: \_\_\_\_\_ Dates (YYYY/MON/DD): \_\_\_\_\_

Last Menstrual Period (YYYY/MON/DD): \_\_\_\_\_

Uterine Size (weeks): \_\_\_\_\_ Date of Exam (YYYY/MON/DD): \_\_\_\_\_

**Medical History relevant to this referral:** \_\_\_\_\_

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

**Medications:** \_\_\_\_\_

**Allergies:** \_\_\_\_\_

**\*ULTRASOUND WILL BE ARRANGED BY THE ABORTION CARE PROVIDER\***

\_\_\_\_\_  
Most Responsible Health Care Provider Name  
(Please Print)

Phone: \_\_\_\_\_

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

\_\_\_\_\_  
Most Responsible Health Care Provider Signature

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

