Nova Scotia Women's Choice Clinic
REFERRAL FORM

Telephone: (902) 473-2362 Fax: (902) 473-8468

Date (YYYY-MM-DD): ___________________

❑ **Medical Abortion** ❑ **Surgical Abortion** ❑ **Undecided**

Name: ___________________________________, ____________________________ ____________________________

Last First Middle

HCN: _________________________ Expiry: _________________________ DOB (YYYY-MM-DD): _________________

Address: ____

City: ____ Province: ___________________ Postal Code: ________________

Phone: ___________________________Voicemail? ❑ Y ❑ N Other Phone: ___________________Voicemail? ❑ Y ❑ N

Interpretation services required? ❑ Y ❑ N Language: ____

Gynecological History

Grava (G) Paragravida (P) Therapeutic Abortion (TA) Spontaneous Abortion (SA)

Previous ectopic/tubal pregnancy? ❑ Y ❑ N

Caesarean section #: _________ Dates (YYYY-MM-DD): ___________________

Vaginal delivery #: ________Dates (YYYY-MM-DD): ___________________

LMP: ___________________ Uterine Size (weeks): __________ Date (YYYY-MM-DD) of Exam: _____________________

Medical History relevant to this referral: ____

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Medications: ____

____

Allergies: ____

ULTRASOUND WILL BE ARRANGED BY THE ABORTION CARE PROVIDER

____

Physician Name (Please Print)

____

Physician Signature

Phone ____

Address ______________________________________

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Referral Forms