

First Trimester Surgical Abortion Referral Gynaecology Ambulatory Procedure Unit (APU)

Gynaecology Ambulatory Procedure Unit
4th Floor, St. Catharines Site of Niagara Health 905-378-4647 Ext 43422 or 44757
Open Tuesday and Thursday 0800 – 1600
Fax: 289-398-1053

Mandatory: This form will not be accepted if the Options box is not checked and Section 1 is incomplete

Options counselling for Parenting or Adoption were discussed with the patient

SECTION 1 Referring Health Care Provider To Complete Section 1	Patient's Name:		Patient's Phone Number:		
	<i>* Make sure the patient will answer a call from Niagara Health, call display may show an unknown number *</i>				
	Health Card Number:		Height:	Weight:	
	Family Doctor:		Date of Birth: (dd/mm/yyyy)		
	Referring Clinician:		Referring Doctor/Clinician Phone Number:		
	Reason for this referral: <input type="checkbox"/> Surgical abortion <12 weeks gestation <input type="checkbox"/> Surgical abortion <12 weeks gestation with IUD insertion (Rx)		Clinical History: LMP: _____ Gestational Age: _____ <input type="checkbox"/> Gestational age dating stated <input type="checkbox"/> Positive pregnancy urine test Gravida _____ Para _____ Abortus _____		
	Diagnostics completed (optional) <input type="checkbox"/> Ultrasound TA completed (dd/mm/yyyy) _____ Location: _____ <input type="checkbox"/> Beta hCG completed (dd/mm/yyyy) _____ Location: _____				
_____ Print Referring Physician / Clinician Name		_____ Referring Physician / Clinician Signature		_____ CPSO Number	
		_____ Date (dd/mm/yyyy)			
SECTION 2 Completed By APU Nurse	According to Medical Directive 710-120-004 Gynaecologist Name: _____		Notes		
	<input type="checkbox"/> Ultrasound for the performance of Early Pregnancy U/S – TA/TV <input type="checkbox"/> Beta hCG <input type="checkbox"/> CBC <input type="checkbox"/> Group and Screen				
_____ Print Gynaecology Nurse Name		_____ Gynaecology Nurse Signature		_____ Date (dd/mm/yyyy)	
		_____ Time (hh:mm)			
SECTION 3 Completed By APU Clerk	<input type="checkbox"/> Called the patient with their appointment day, times and location Attempt 2 _____		<input type="checkbox"/> Book procedure in BCS and do a PRE-CLI account <input type="checkbox"/> Booking account number for this visit Account No.: _____		
	<input type="checkbox"/> Inform the patient to drink 1 litre (4 cups) of fluid one hour before their ultrasound appointment (water, juice, coffee or tea) for a full bladder.		<input type="checkbox"/> This referral is faxed to SCS Ultrasound <input type="checkbox"/> This referral is copied for SCS 4th Floor Lab		
_____ Print Ward Clerk Name		_____ Ward Clerk Signature		_____ Date (dd/mm/yyyy)	
		_____ Time (hh:mm)			

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