Thunder Bay Regional Health Sciences Centre

TERMINATION OF PREGNANCY
REFERRAL FORM

Place Patient Label with Barcode Here

GUIDELINES

1. Physician or Nurse Practitioner to complete referral.
2. Fax to Surgical Assessment Program at 855-610-2254.
3. ***Tell the patient to call 807-622-0055 to book their appointment.***
4. A letter can be sent in lieu of this form provided it clearly contains all the necessary information requested on the form
5. Form to be maintained as part of the legal medical record.
6. Incomplete or illegible referrals will be declined back to the referring provider.
7. Questions - contact the Surgical Central Intake and Assessment Program at 807-684-7103

PATIENT INFORMATION

LAST NAME		ADDRESS	
FIRST NAME		CITY	
DATE OF BIRTH		POSTAL CODE	
HEALTH CARD		HOME PHONE	
VERSION CODE		CELL PHONE	

CONSENT TO REFERRAL

Did the patient provide consent to send the referral? ☐ YES ☐ NO If no, why not?

Does the patient require an interpreter? ☐ YES ☐ NO If yes, which language?

Does the patient have a family doctor / nurse practitioner? ☐ YES ☐ NO

Does the patient consent to records being sent to the family doctor / nurse practitioner? ☐ YES ☐ NO

Does the patient have a preferred provider? ☐ YES ☐ NO If yes, name of provider?

REFERRAL INFORMATION

☐ TERMINATION OF PREGNANCY	☐ MISSED ABORTION / RETAINED PRODUCTS
GESTATIONAL AGE AT TIME OF REFERRAL:	DUE DATE:
GROUP & SCREEN ☐ Attached ☐ Pending	
ULTRASOUND ☐ Attached ☐ Pending	

MEDICAL HISTORY

Provide the patient's past medical history, including past obstetrical history, current medications, and allergies OR the Cumulative Patient Profile (CPP) health profile

REFERRING PHYSICIAN / NURSE PRACTITIONER INFORMATION

NAME		SIGNATURE	
PHONE			
FAX		DATE	

TREFPREGTERM