niagarahealth

Extraordinary Caring. Every Person. Every Time.

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:

** Make sure the patient will answer a call from Niagara Health, call display may show an unknown number **

Health Card Number:

Height: Weight:

Family Doctor:

Date of Birth: (dd/mm/yyyy)

Referring Clinician:

Referring Doctor/Clinician Phone Number:

Reason for this referral:

☐ Surgical abortion <12 weeks gestation

☐ Surgical abortion <12 weeks gestation with IUD insertion (Rx)

Diagnostics completed (optional)

☐ Ultrasound TA completed (dd/mm/yyyy) _____

Location: _____

☐ Beta hCG completed (dd/mm/yyyy) _____

Location: _____

Clinical History:

LMP: _____ Gestational Age: _____

☐ Gestational age dating stated

☐ Positive pregnancy urine test

Gravida _____ **Para** _____ **Abortus** _____

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: _____

☐ Ultrasound for the performance of Early Pregnancy U/S − TA/TV

☐ Beta hCG

☐ CBC

☐ Group and Screen

Notes

Print Gynaecology Nurse Name | Gynaecology Nurse Signature | Date (dd/mm/yyyy) | Time (hh:mm)

SECTION 3 Completed By APU Clerk

☐ Called the patient with their appointment day, times and location

Attempt 2 _____

☐ 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.

☐ Book procedure in BCS and do a PRE−CLI account

☐ Booking account number for this visit

Account No.: _____

☐ This referral is faxed to SCS Ultrasound

☐ This referral is copied for SCS 4th Floor Lab

Print Ward Clerk Name | Ward Clerk Signature | Date (dd/mm/yyyy) | Time (hh:mm)

Rev. 11/2022(v1)

REF60

Chart Copy − Do Not Destroy