Trillium Health Partners
Better Together

Early Pregnancy Clinic (EPC) Referral Form

Trillium Health Partners - Credit Valley Hospital
2200 Eglington Avenue West, Mississauga ON L5M2N1
Phone: (905) 813-3862
Fax referrals to: (905) 813-4475

Last Name: _____ First Name: _____

Date of Birth (DD/MM/YYYY): _____/_____/_____

Health card #: _____

MRN #: _____

CSN #: _____

THP use only

Affix patient encounter label here/complete all fields if label not available.

PATIENT DEMOGRAPHICS:

Last Name: _____ First Name: _____ Date of Birth (DD/MM/YYYY): _____/_____/_____

Health Card #: _____ Legal Sex: ☐ Female ☐ Male ☐ Non-Binary ☐ Unknown ☐ X

Address: _____ City: _____ Province: _____ Postal Code: _____

Telephone number: _____ Mobile number: _____ Email Address:_____

Reason for Referral

The EPC provides urgent assessment of pregnant persons with less than 13 weeks gestation who are experiencing one of the following conditions:

☐ Fetal demise (under 12 weeks, 6 days)

☐ Incomplete abortion

☐ Missed abortion

☐ Spontaneous abortion

☐ Suspected Ectopic/ Molar Pregnancy that is Stable

Comments:

Please complete and send the following investigations:

☐ **CBC/Beta hCG**

☐ **Group & Screen**

☐ **Ultrasound –** must have a documented pregnancy with measurements of less than 13 weeks gestation

Attach all results to referral

Please note: Suspected Ectopic or Molar Pregnancies that are unstable (suspected of rupture) should go to the closest Emergency Department.

Referrals to EPC will not be accepted for the following concerns:

- Live Intrauterine pregnancy: refer to a local obstetrical care provider
- Vaginal Bleeding after 13 weeks gestation – send to the nearest Emergency Department if bleeding is heavy
- Therapeutic Abortion/ Family Planning
- Postpartum patients for retained products; send to the hospital where they gave birth.
- Retained products of conception less than 3cm, unless bleeding greater than 3 weeks post loss or no resumption of period by 6 weeks

FOR INTERNAL USE ONLY

Reviewed by: _____ **Date:** _____

REFERRING PROVIDER:

Name of Referring Provider (Last Name, First Name- as listed in CPSO): _____

Address: _____ City: _____ Province: _____ Postal Code: _____

Phone number: _____ Fax number: _____ CPSO #: _____ Billing (OHIP) #: _____

Signature: _____ Date: _____