Waikato District Health Board

Women's Assessment Unit

Patient Label

Name:

NHI: DOB:

Address:

Referral to Early Pregnancy Assessment Clinic (EPAC)

Fax to 0800 843 521

Referring doctor/LMC/clinic: Date: (dd/mm/yy) Time: (24 hour)

Phone: Mobile phone: Fax:

Address:

Patient contact details: Phone/mobile

Is the patient available at short notice if a cancellation becomes available? Yes ☐ No ☐

MANDATORY INFORMATION - patient history (See overleaf for guidelines)

Reason for referral: **<14/40 gestation** only-see criteria in guidelines

Gestation: G / P LMP

EDD:

Date of positve pregnancy test: (dd/mm/yy) Beta HCG result:

MANDATORY INFORMATION - patient investigations

Blood tests: 1st A/N bloods ☐ or Group and screen ☐

Serum HCG ☐ Date taken: (dd/mm/yy)

Previous U/S scan: Yes ☐ No ☐ Date of scan: (dd/mm/yy)

Scanned by: Hamilton Radiology ☐ Waikato Radiology ☐

Waikato Hospital ☐ Other:

Scan report to be faxed to **0800 843 521** Fax sent: ☐

Relevant history:

Allergies/alerts:

NZ resident: Yes ☐ No ☐ Interpreter required? Yes ☐ No ☐ Language:

Referrer signature: Name:

Designation: Date: (dd/mm/yy)

Time: (24 hour)

EPAC REFERRAL