Reproductive Options and Services (ROSE) Clinic
REFERRAL FORM

Telephone: 902-473-2362 Fax: 902-473-8468

Date (YYYY/MON/DD): _____

❑ **Medical Abortion** ❑ **Surgical Abortion** ❑ **Undecided**

Name: _____ , _____ , _____
Last First Middle

HCN: _____ Expiry: _____ DOB (YYYY/MON/DD): _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Phone: _____ Voicemail? ❑ Y ❑ N Other Phone: _____ Voicemail? ❑ Y ❑ N

Interpretation services required? ❑ Yes ❑ No Language: _____

Gynecological History

Gravida (G) _____ Paragravida (P) _____ Therapeutic Abortion (TA) _____ Spontaneous Abortion (SA) _____

Previous ectopic/tubal pregnancy? ❑ Yes ❑ No

Cesarean section #: _____ Dates (YYYY/MON/DD): _____

Vaginal delivery #: _____ Dates (YYYY/MON/DD): _____

Last Menstrual Period (YYYY/MON/DD): _____

Uterine Size (weeks): _____ Date of Exam (YYYY/MON/DD): _____

Medical History relevant to this referral: _____

_____

_____

_____

Medications: _____

_____

Allergies: _____

ULTRASOUND WILL BE ARRANGED BY THE ABORTION CARE PROVIDER

_____
Most Responsible Health Care Provider Name
(Please Print)

_____
Most Responsible Health Care Provider Signature

Phone: _____

Address: _____

_____

_____

_____