Early Pregnancy Assessment Service
Coffs Harbour Health Campus
Ph.: 6656 7663 Fax: 6656 5118

NSW GOVERNMENT Health
Mid North Coast
Local Health District

Referral Form

DATE: _____ **TIME**: _____

REFERRING SERVICE: **EMERGENCY DEPT** **SURGICAL** **MATERNITY** **GP** **OBSTETRICIAN**

AFFIX MRN LABEL HERE

GRAVIDA: ___ **PARITY:** ___ **MISCARRIAGES:** ___ **TOP:** ___ **LMP:** _____ **GESTATION:** _____**WEEKS**

ABDOMINAL PAIN: **NO** **YES** **COMMENT**: _____

VAGINAL BLEEDING: **NO** **YES** **COMMENT:** _____

PATHOLOGY & RADIOLOGY INVESTIGATIONS:
ALL WOMEN WHO PRESENT IN FIRST TRIMESTER WITH ABDOMINAL PAIN AND P.V. BLEEDING REQUIRE THE FOLLOWING BASELINE PATHOLOGY TESTS. IT IS PREFERABLE THAT THE WOMAN BE REFERRED TO HOSPITAL PATHOLOGY SERVICES.

FULL BLOOD COUNT	YES	NO
BETA HCG	YES	NO
BLOOD GROUP & RBC ANTIBODIES	YES	NO

ALL RHESUS NEGATIVE WOMEN WHO PRESENT WITH VAGINAL BLEEDING IN PREGNANCY REQUIRE COUNSELLING FOR ANTI-D. THE DOSE IS DEPENDANT ON THE GESTATION OF THE PREGNANCY. REFER TO RHESUS D POLICY DIRECTIVE AND DISCUSS WITH SENIOR STAFF OR O+G TEAM.

ANTI-D GIVEN: YES NO DOSE: _____

ULTRASOUND PERFORMED: YES NO **SERVICE:** CHHC BEACHSIDE COFFS HARBOUR

THE MEDICAL IMAGING DEPARTMENT HAS APPOINTMENTS AVAILABLE ON A DAILY BASIS FOR EPAS AND PCS. PERFORM AN E-ORDER IN POWERCHART OR PHONE EXT 7458 TO BOOK.

DIAGNOSIS (PLEASE CIRCLE): **INTRAUTERINE VIABLE PREGNANCY** **THREATENED MISCARRIAGE**

MISCARRIAGE: **INCOMPLETE** **MISSED** **FETAL DEMISE** **PREGNANCY OF UNKNOWN LOCATION**

_____

_____

_____

_____

CLINICIANS NAME: _____

CLINICIANS SIGNATURE: _____

DESIGNATION: _____

Early Pregnancy Assessment Service
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Mid North Coast Local Health District
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