

TRIAL



Queensland Government

Central Queensland Hospital and Health Service

Early Pregnancy Assessment Service (EPAS) REFERRAL

Facility / Unit: Rockhampton Hospital

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Phone:

Date of birth:

Sex: M F I

Date of referral:

GP / Consultant Name:

Provider No:

GP Practice / Department:

Referral to:

Regular periods: No Yes

LNMP:

Gestation:/ 40

Pregnancy confirmed by: Urine test

BhCG USS

Blood group + Antibodies and BhCG collected

Blood group:

USS attended/booked

Result :

Criteria

- Less than 20 weeks gestation
 Clinically stable with:
 Threatened miscarriage
 Ectopic pregnancy
 Pregnancy of unknown location (PUL)
 Non-viable pregnancy/Fetal demise -USS
 Missed miscarriage:
 Other:

Relevant history: G: P: M: T:.....

- Previous STI / PID
 Previous pelvic surgery
 Endometrioses
 Contraceptive Use
 Smoking

Please send signed referrals to FAX: (07) 4920 6862

EPAS information given to patient: Yes No

For any further enquiries ring EPAS on (07) 49206438 or email EPAS.Rockhampton@health.qld.gov.au

Staff Name (print): Designation:

Signature: Date:

DO NOT WRITE IN THIS BINDING MARGIN

All clinical forms creation and amendments must be conducted through Health Information Unit

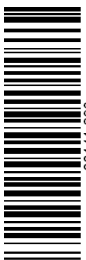
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