fraserhealth

EARLY PREGNANCY ASSESSMENT CLINIC REFERRAL (EPAC)

Jim Pattison Outpatient Care and Surgery Centre

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JPOCSC Maternity Clinics 9750 140th Street, Surrey, BC Phone: (604) 582-4558 Ext 763994 Fax: (604) 587-4548

PLEASE COMPLETE IN FULL AND PRINT CLEARLY

Patient's Full Legal Name: _____ (Last) _____ (First) _____ (Middle)

Other Name(s) (if applicable): _____

Personal Health Number: _____ **Date of Birth:** ___/___/___ (DD MM YYYY)

Address: _____ (Street) _____ (City) _____ (Province) _____ (Postal Code)

Home Phone: _____ **Cell Phone:** _____

***Interpreter Required:** ☐ **No** ☐ **Yes** **Language:** _____

Insurance Type: ☐ MSP ☐ WCB ☐ Out-of-Province ☐ Self-Pay Other: _____ RCMP or Armed Forces #: _____

G T P SA TA E L	**Date of first positive pregnancy test** _____
LMP: (DD/MM/YY) **Gestational Age:** ☐ By LMP ☐ By Ultrasound	**Ultrasound (if done):** Date _____ Facility _____ Gest Age _____
Reason for Referral (Must be 6+0 weeks-12+6 weeks gestation) ☐ Cramping, spotting in 1st Trimester ☐ Known fetal demise ☐ Other	**EPAC does not accept referrals for women with a known ectopic or high suspicion of ectopic. Please advise patient to go to emergency.**
IMPORTANT: PLEASE ENSURE THE FOLLOWING ARE ATTACHED (to avoid delays) ☐ Ultrasound reports ☐ Blood Type ☐ hCG level results (if available)	**It is our intention to see patients within 3-5 business days.** **NOTE: This is not a walk in service.**

Family Physician (if different from referring source)

Name: _____

MSP #. _____

Phone: _____ Fax: _____

☐ Patient has no GP/NP

Referring Health Care Provider

Name: _____

MSP #: _____

Phone: _____ Fax: _____

☐ GP ☐ NP ☐ RM ☐ OB/GYN ☐ Other: _____

For Office use only: ☐ Missing lab work requested on _____ (date)

☐ Interpreter needed _____ ☐ Interpreter Booked

Appointment:

Date: ___/___/___ (DD MM YYYY) ☐ Follow-Up **Date:** ___/___/___ (DD MM YYYY)

Time: _____ **Time:** _____

Appointment will be given directly to patient.

Referral From:

☐ Emergency
☐ Physician/ Midwife's Office
☐ Self Referral
☐ Other

Referring Practitioner Signature: _____ **Date of Referral:** _____