


**REQUEST FOR PREGNANCY LOSS ON USS (ASYMPTOMATIC) / EPAS APPOINTMENT
 FAX 03 4215 2086; PHONE 4215 2060**

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| REFERRING GENERAL PRACTITIONER DETAILS: Name: Practice Name: Address: Telephone: Fax: Email: |  |
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| PATIENT DETAILS: | | |
| Family Name: | Previous Name: | Given Name: |
| Address: | Suburb: | Postcode: |
| Telephone: | | |
| Next of Kin or Contact Person: | | |
| DOB: | Age: | Medicare Number: |

Interpreter required: Yes No Language:

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| PLEASE CIRCLE REASON FOR PATIENT REFERRAL: (ONLY for listed conditions) |
| 1. Blighted ovum with USS confirmation 2. Anembryonic pregnancy with USS confirmation 3. Early fetal demise / nonviable pregnancy on USS* 4. Missed abortion / Missed miscarriage on USS |

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| *Early fetal demise / nonviable pregnancy are defined on transvaginal USS by findings of: |
| 1. Fetal pole length > 7mm but no fetal heart activity seen 2. Gestational sac >25mm with no fetal pole seen 3. No interval growth in fetal pole over a minimum interval of 1/52 |

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| Direct referral to EPAS <u>not available for:</u> |
| 1. Known or suspected ectopic pregnancy or pregnancy of unknown location 2. Symptomatic miscarriage/molar pregnancy (pain, passage of clots or bleeding other than spotting) 3. Complicated miscarriage (complicated by haemorrhage, shock or signs of infection) 4. Known or suspected heterotopic pregnancy |

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| LNMP: |
| Blood Grp: |

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| Please circle location where USS was undertaken (enclose result with referral) |
| 1. BMI 2. GMI 3. Lake Imaging 4. Other, please specify: |

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| PAST MEDICAL Hx: |
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| MEDICATIONS: |
| ALLERGIES: |
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| Signature of Referring Physician: Date: |
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