Early Pregnancy Complications Clinic (EPCC) Referral Form

6th Floor Gynecology Clinics, 6A Women's Site, IWK Health Centre
Open Monday–Friday 8:30 am to 10:00 am (during regular business hours)
Patients will be seen Monday – Friday, 8:30am – 10:00am.

PATIENTS REQUIRE AN APPOINTMENT – NPO not required

The patient will be contacted by an Early Pregnancy Complication Clinic (EPCC) nurse 24–48 hours after receiving the consult from the referring physician to book an appointment.

Referral Requirements:

- Ultrasound report, blood type and serum beta HCG.
  Once all the information is received, clinic staff will contact patient to book appointment time.

Appropriate Patient Population for Referral:

- Patients experiencing missed abortion that have already been diagnosed by ultrasound.
- Patients experiencing an incomplete abortion – patients must be completely stable and able to wait up to 48 hours for care.
- Follow up to determine if complete abortion has occurred **(from Emergency Department only)**.
- Follow up for possible ectopic pregnancy that is completely stable and appropriate to wait up to 48 hours for care, **must be discussed with gynecologist on call prior to referral.**

If you are unsure if patient is appropriate for referral, contact the gynecology resident on call through the IWK Switchboard at 470–8888.

Patients with viable gestations or threatened abortions are NOT appropriate for this clinic.

- Options for ongoing patient management are reviewed during the appointment. If a D&C is chosen and the patient is stable, the procedure will not be done on the same day. Elective D&Cs are booked according to OR availability.

Referral Date (dd/mm/yyyy): ____________________ Referring Physician ____________________

Patient Name: ____________________ Patient DOB (dd/mm/yyyy): ____________________

Patient Health Card #: ____________________ Patient Contact #: ____________________

Reason for Referral:

❑ Missed Abortion ❑ Complete Abortion ❑ Query Complete Abortion
❑ Incomplete Abortion ❑ Ectopic Pregnancy ❑ Query Ectopic Pregnancy

Reports Required:

Serum HCG ______________ Ultrasound ______________ Blood type ______________

Win Rho (Date (dd/mm/yyyy) and Dose given) ____________________

****** Once all information is obtained, please fax referral to 470–7056 ******

Please give the attached instructions to patient.