IWK Health Centre

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.