Early Pregnancy Assessment Service (EPAS)

Patient Referral

Fax to (02) 9382 6638

Number of Pages including this Coversheet (……...)   Date ____/____/____

Attention: Prof W Ledger

Patient Details

Surname ________________________ First Name_____________________

Address ____

____ Postcode______

D.O.B _____/_____/_____ Medicare Number_____________________

Phone _______________________ Mob __________________________

G ____P____ LMP ____/____/_____ Weeks Gestation ___/40

Symptoms

____

____

Blood Group__________________ Date Taken ___/___/___

Antibody screen _______________ Date Taken ___/___/___

Anti-D given Y / N Dose _____IU Date ___/___/___

FBC ____________________ Date Taken ___/___/___

ß hCG ____________________ Date Taken ___/___/___

Ultrasound Date Performed ___/___/___ ☐ Please attach report

Referring Doctor Details: Date of referral ___/___/___

Doctor ______________________________ Provider No _______________

Address ____

____ Postcode_______

Phone ________________________ Fax: ___________________________

Thank you for completing the above details.

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