



FAMILY NAME		MRN
GIVEN NAME		
D.O.B.	M.O.	
ADDRESS		
PH		
M / C		
ADM	DD / MM / YYYY	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE		

EARLY PREGNANCY ASSESSMENT SERVICE (EPAS) REFERRAL

Email completed form to EPAS on nbhepas@healthscope.com.au

Assessment Date: ___/___/___ Referred By: ED GP
 Self Other _____

Patient's Contact Phone _____

GP Name _____ Name of Practice _____

Allergies _____

Blood Group _____ Antibody Screen _____ AntiD Given: Yes No

Pregnancy Confirmed: Yes No If by serum, Pathology Provider _____

LMP _____

Women are not accepted into EPAS for **a) confirmation of pregnancy, b) retained products of conception, c) termination of pregnancy, d) complete miscarriage.**

Women with unstable abdominal pain and PV bleeding to be referred to Emergency department.

Previous Obstetric History:

G _____ P _____ Miscarriage _____ Termination _____

Reason for Referral:

Ultrasound Performed: Yes No If yes, was the report emailed with the referral? Yes No

If no, Ultrasound Provider _____ Date: _____

Pathology Performed: Yes No If yes, were the results faxed with the referral? Yes No

If no, Pathology Provider _____ Date: ___/___/___

Referring Doctor Name _____ Signature _____

Designation _____ Date: ___/___/___

Provider Number _____ Phone Contact _____

- Email this EPAS referral to nbhepas@healthscope.com.au
- Provide woman with NBH Outpatient EPAS information brochure.
- Advise woman that:
 - 1) She will receive a call the morning of the next business day from the EPAS Midwife to discuss ongoing care.
 - 2) To be prepared to stay up to 4 hours for the appointment.
 - 3) Fasting is not a requirement.
 - 4) A full bladder is not necessary.
 - 5) Surgery (if required) may not be performed on the same day.
 - 6) Any abdominal pain and/or PV bleeding present to the Emergency Department.

If they have not received a call by 11am, please call the Outpatient Clinic on:
9105 5020

Holes punched as per A52828 - 2012
 BINDING MARGIN - NO WRITING

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FEB18/V2