Northern Beaches Hospital

EARLY PREGNANCY ASSESSMENT SERVICE (EPAS) REFERRAL

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

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:

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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 and please call the outpatients clinic on 9105 5020
- Provide woman with NBH Outpatient EPAS information brochure.
- Advise woman that:
  1) She will receive a call within the next 2 working days from EPAS midwife to discuss ongoing care
  2) To be prepared to attend hospital for a face to face 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.

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