TelAbortion
Safe. Effective. Private. Convenient.

carafem
Compassionate, convenient, abortion care.

REFERRAL FORM

Your patient should call the TelAbortion coordinator to schedule a videoevaluation. The TelAbortion provider will conduct a comprehensive screening to confirm eligibility for the service, however please confirm these basic criteria before referring your patient:

☐ Has access to a device (phone, tablet, computer) with internet connection, a webcam, and a microphone

☐ Lives in Illinois, Georgia, Maryland, or Washington D.C. OR is able to have the consult and receive the package in Illinois, Georgia, Maryland or DC

☐ Does not have any contraindications to medical abortion, including:
- o IUD in place
- o Chronic adrenal failure
- o Inherited porphyrias
- o Concurrent long-term corticosteroid therapy
- o History of allergy to mifepristone, misoprostol, or other prostaglandin
- o Hemorrhagic disorders or concurrent anticoagulant therapy

☐ Is less than 70 days' LMP

☐ Is 15 years old or older

Patient Details

_____ _____/_____/_____

Name (First, Last) *DOB (mm/dd/yyyy)*

Complete if known:

LMP: mm____/ dd____/ yy____ G: _____ P:_____

Any known medical problems: _____

Screening tests

Ultrasound or pelvic exam report: ☐ Attached ☐ Will fax later/report not received yet

Rh type: ☐ Positive ☐ Negative ☐ Unknown (test results pending)

Source of info for Rh type: ☐ Patient self-report ☐ Blood test (attached)

☐ Blood donor card ☐ Blood test (will fax later)

Hemoglobin or Hematocrit report if history of anemia:

☐ Attached ☐ Will fax later/report not received yet

Referring provider information

_____

Name (First, Last) *e-mail address*

_____

Street address (Street, State, Zip Code)

_____

Phone number *Fax number*

Thank you for this referral. The TelAbortion provider (carafem) will have a medical abortion consultation with your patient by videoconference. If the patient is eligible, carafem will mail the medications and will conduct a follow-up consult.

Please indicate if you would like to be involved in the follow-up care of this patient: ☐ Yes ☐ No

I confirm that all the information I have provided on this form and the medical records I provide to carafem are accurate and complete. I have received permission from my patient to share this information with the TelAbortion provider.

_____ _____/_____/_____

Signature Date (mm.dd.yyyy)

Please fax this form and all test results to 224-330-1064.

Contact information: Phone: (877) 721-2596
E-mail: health.projects@carafem.org