TELABORTION REFERRAL FORM

***** Instruct the patient to call the PPMNS Coordinator to discuss TelAbortion (612-821-6141). *****

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 phone/tablet/computer with internet connection, a webcam, and a microphone
- ☐ Lives in MN or is able to have the telehealth video consult and receive the package in MN
- ☐ Is less than 70 days from LMP
- ☐ Is 18 years old or older

The patient will need the following tests before receiving TelAbortion medications. Check the ones the patient has already had prior and those included with this referral.

TEST	**Has Completed**	**Report included with referral form**
Ultrasound report with intrauterine pregnancy and gestational age <70 days (10 weeks)		
Documentation of Rh type (if Rh negative self-report allowed)		
Hemoglobin or hematocrit if signs or symptoms of anemia are present		

Note: If the tests have not been done at the time of referral, they can be done after referral.

PATIENT INFORMATION	
Name:	
Date of birth:	First day of last menstrual period, if known:

REFERRING PROVIDER INFORMATION		
Name:		
Address:		
Phone:	Fax:	Email:

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

_____ ____/____/____

Referring provider signature Date

Send this form and all available test results to the PPMNS TelAbortion Coordinator.

Phone: 612-821-6141 • Fax: 651-900-8290 (Attn: Shay) • Email: research@ppncs.org