TELABORTION REFERRAL FORM

PATIENT INFORMATION

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

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

- ☐ Ultrasound showing an intrauterine pregnancy with a gestational age <70 days (10 weeks)
- ☐ Documentation of Rh type (may include a blood donor card); patient self-report allowed if Rh negative
- ☐ 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.

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 PPRM TelAbortion Coordinator.

Attached test results:
☐ Ultrasound report ☐ Hemoglobin or hematocrit
☐ Documentation of Rh type ☐ Other: _____

Instruct patient to call the PPRM TelAbortion coordinator to schedule a prescreen phone call and video consultation.

Phone: 303-813-7712 • Fax: 303-321-0498 (Attn: Ann or Melissa) • Email: research@pprm.org