

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 or is able to have the consult and receive the package in Illinois
- Does not have any contraindications to medical abortion, including:
 - IUD in place
 - Chronic adrenal failure
 - Inherited porphyrias
 - Concurrent long-term corticosteroid therapy
 - History of allergy to mifepristone, misoprostol, or other prostaglandin
 - 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