Alberta Health Services

Affix patient label within this box

Early Pregnancy Assessment Referral
(Calgary Zone Early Pregnancy Assessment)

Submit completed referral by **fax** to 403-944-1111
Call FMC at 403-944-4460 or SHC at 403-956-2011 for inquiries.
For more information visit – *http://www.albertahealthservices.ca/services/Page10659.aspx*

Date *(yyyy-Mon-dd)*

Patient Information

First Name	Last Name	Phone

Address	Postal Code	Personal Healthcare Number

City	Province	Date of Birth *(yyyy-Mon-dd)*

Language Barrier *(if yes, please specify)*	Special Needs *(e.g. wheelchair)*

Patient History

Blood Type	Rh	LMP	G	P	A

Gestational Age
☐ By Date *(yyyy-Mon-dd)* _____ ☐ By Ultrasound _____

Investigations

Select which of the following investigations are attached
☐ Transvaginal U/S Report
☐ Bloodwork
- ☐ Rh + Blood Type
- ☐ Antibody Screening
- ☐ Beta HCG

☐ Other _____

Referring Physician

Name	Phone	Fax

Address	Practice ID

Please specify department
☐ Urgent Care _____ ☐ Emergency _____ _ Other _____