



WOMEN'S COLLEGE HOSPITAL
Healthcare | REVOLUTIONIZED
76 Grenville Street Toronto, Ontario M5S 1B2

Bay Centre for Birth Control - Access Centre
Tel: 416-351-3708 / Fax: 416-323-6319

**BAY CENTRE FOR BIRTH CONTROL (BCBC)
REFERRAL FORM – SECOND TRIMESTER ABORTION**

PATIENT INFORMATION
(Affix Patient Label/Identification Here)

Name: _____ Date of Birth: ____ / ____ / ____
DD/MM/YYYY
Health Card: _____ Version Code: _____
Address: _____
Telephone: _____ Alternate: _____

Referral Date: ____ / ____ / ____
DD/MM/YYYY

ADDITIONAL PATIENT INFORMATION

Preferred name: _____

Gender: _____ Pronouns: He/Him She/Her They/Them Other _____

Other insurance coverage (IFH, UHIP, other) Self-pay

Language spoken: _____ Interpreter required: Yes No

Allergies: _____

REFERRING PROVIDER INFORMATION

Name: _____ Billing number: _____

Address: _____

Telephone: _____

Fax: _____ Signature: _____

FAMILY DOCTOR AND/OR OBSTETRICIAN-GYNECOLOGIST INFORMATION (IF APPLICABLE)

Family doctor's name and/or Obstetrician-Gynecologist's name (if applicable): _____

Telephone: _____ Fax: _____

Genetic counsellor's name: _____ Phone: _____

REASON FOR REFERRAL

Diagnosis and indication for dilation and evacuation (if known):

Gestational age at date of referral: _____ Estimated due date: _____

Date of ultrasound: _____ DD/MM/YYYY

Obstetrical history: Gravida _____ Para _____ # Spontaneous vaginal delivery _____ # C-Sections _____

CLINICAL INFORMATION / FINDINGS

Past and current medical history: (Include medication list & cumulative patient profile, if available)

Please attach the following reports:

- ▶ Blood work - current pregnancy
- ▶ Ultrasounds - current pregnancy
- ▶ Consults related to current condition
- ▶ Medical history

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