WCHI
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: _____
DD/MM/YYYY

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