

Thank you for seeing: ..... DOB: .....

Address: .....

Medicare Number: ..... Expiry: .....

Preferred method of contact: .....

T: ..... M: .....

Email: .....

Who has requested help with her unplanned pregnancy. I have offered counselling and have discussed the medical risks of termination of pregnancy. I am satisfied the information provided was understood.

Date of LMP:.....G:.....P:.....T:.....M:.....

Allergies:.....

Medications:.....

Blood Group:.....

Special Precautions:.....

.....

**Referring Practitioner**

Name:.....

Provider #:.....

Address:.....

.....

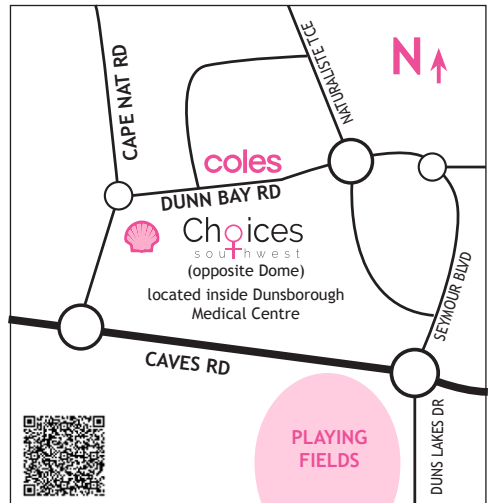
Telephone:.....

Fax:.....

Email:.....

Signature:.....

Date:.....



**Please fax referral to: 02 8275 8524**

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