Medical Termination of Pregnancy (mTOP) GP Referral Form

Sexual Health Quarters

Date _____

Client details

First name_____ Family name _____

Date of Birth _____ Phone number:_____

Address _____

_____

Interpreter required

☐Yes ☐No

If yes, please specify language: _____

History

LMP _____

Regular menstrual cycle?

☐Yes ☐No

If yes, length of cycle (days): _____

Current contraceptive method _____

Obstetric history

Gravity_____ Parity_____

Miscarriages_____ Terminations of Pregnancy_____ Ectopic Pregnancies_____

Date of most recent delivery_____ Mode of delivery: Vaginal_____ Caesarean section_____

Do any of the following contraindications apply? (select all that apply)

☐ IUD in-situ
☐ Suspected ectopic pregnancy
☐ Suspected / confirmed pelvic infection
☐ Chronic Adrenal Failure
☐ Systemic exogenous steroid use
☐ Anticoagulant use
☐ Haemorrhagic disorder
☐ Allergy to Mifepristone and/or Misoprostol
☐ Lack of access to emergency services
(e.g. residing > 2 hours drive from nearest Emergency Department)
☐ None of the above

Investigations (please attach results)

Required

☐ Pelvic Ultrasound – with confirmation of an Intrauterine Pregnancy (presence of yolk sac or fetal pole) under 9 weeks gestation

☐ Haemoglobin

Recommended

☐ Chlamydia / Gonorrhoea PCR (self obtained vaginal swab preferable)

☐ HIV / Syphilis serology

☐ quantitative beta HCG

Discussion

☐ The client has had an opportunity to discuss their options for this pregnancy (including continuing with the pregnancy, parenting, adoption and termination of pregnancy)

☐ The client is aware of the mTOP procedure process (for more information visit - shq.org.au/medical-abortion)

☐ The client is aware of the of the short/long-term risks associated with mTOP (for more information visit - shq.org.au/medical-abortion)

☐ The client is aware of the costs involved with mTOP at SHQ (for more information visit - shq.org.au/clinic-costs)

☐ The client is aware that provision of mTOP is at the discretion of the consulting clinician at the time of appointment. If mTOP unsuitable at the time of appointment, alternative options will be offered to the client.

☐ I have discussed future contraceptive options with the client.

They are planning to use: _____ (insert contraceptive option here)

Doctors Contact

Please sign and provide your contact details to confirm all the information on this form has been discussed with the client. Alternatively, use a Drs stamp below:

Referring Doctor name_____

Practice_____

Practice Address _____

_____

Contact number _____

Provider number _____

Signature _____Date_____

Drs stamp