family planning nsw
Reproductive & Sexual Health

REFERRAL FORM - ABORTION (MEDICAL & SURGICAL)

FAX COMPLETED FORM TO YOUR NEAREST FPNSW CLINIC:
Ashfield 02 8752 4392 Fairfield 02 9723 0922 Penrith 02 4731 6787
Dubbo 02 6882 3666 Hunter 02 4926 2029

REFERRAL DATE: _____ / _____ / _____

CLIENT DETAILS	
Name	
Address	
Date of birth	Age:
Medicare number	
Phone	M: H: W:

REFERRING DOCTOR	
Name	
Provider number	
Practice address	
Phone	W: M:

CLINICAL HISTORY	
First day of last menstrual period	Date:
Gestation	Weeks: Days: at date: _____ / _____ / _____
Dating US completed	☐ Yes ☐ No If YES – attach copy of report
Blood test completed	☐ Yes ☐ No If YES – attach copy of report
Parity	G: P: Miscarriages: Abortions: Number of multiple pregnancies in the past:
Previous LCS	☐ Yes ☐ No If YES – number:
Previous TOP	☐ Medical TOP ☐ Surgical TOP Comments:
Currently breastfeeding	☐ Yes ☐ No
Smoking	
Alcohol	
Recreational drug use *(Record details, including IV drug use)*	
Weight, height, BMI	Weight: Height: BMI:
General medical history *(Includes medical conditions, current medications, allergies, etc.)*	
Psychosocial considerations *(Includes domestic & family violence, mental health, financial hardship, etc.)*	

Referrer Signature: _____ Date: _____ /_____ /_____