**Referring Doctor’s Name**

**Address**

**Phone number**

**email**

**fax**

**provider number**

Referral for Medical Termination of Intrauterine Pregnancy under 63 days via Telehealth

Dear Gynaecare Team

**Re: Patient’s name**

 **Postal Address**

 **Mobile phone number**

 **Medicare Card Number and expiry date**

Thank you for managing **[Patient’s name]** who has an early intrauterine pregnancy which she would like to terminate using medication.

She **has/has not** had a pelvic ultrasound scan **(attach report)**

She **has/has not** had basic blood tests (Hb, BHCG) **(attach reports)**

She **has/has** **not** had recent chlamydia screening **(attach reports)**

**Past History:**

**Allergies**:

**Current Medications:**

Should any of the above need clarification, please feel free to contact me on **[your phone number].**

Yours sincerely,

Dr **[Your name]**