**Early Pregnancy Unit**

**T:** 020 8321 6506/6070

**E:** [caw-tr.westmidepu@nhs.net](mailto:caw-tr.westmidepu@nhs.net)

**W:** [www.chelwest.nhs.uk/womens-services](http://www.chelwest.nhs.uk/womens-services)

**EARLY PREGNANCY UNIT REFERRAL FORM**

**Please note:** This form must be completed in full

|  |  |  |
| --- | --- | --- |
| Patient's name: |  | |
| Hospital number (or NHS number): |  | |
| Patient's address: | | |
|
|
|
| Daytime telephone number: |  | |
| Mobile telephone number: |  | |
| Date of birth: | Age: |  |
| LMP: | Gestation by dates: |  |
| Normal cycle: | Date of positive pregnancy test: | |
| Previous Obstetric history: | | |
|
|
|
|
| Current problem: | | |
|
|
|
|
|
| Serum hCG result (if taken): | Previous scans in this pregnancy: yes/no | |
| Signature: | Name: | |
| Date: | Phone (with extension): | |

**Please email referral to [caw-tr.westmidepu@nhs.net](mailto:caw-tr.westmidepu@nhs.net)**

EPU Team October 2020