**Early Pregnancy Unit**

**T:** 020 8321 6506/6070

**E:** 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: |
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|
| Daytime telephone number: |  |
| Mobile telephone number: |   |
| Date of birth: | Age:  |   |
| LMP: | Gestation by dates: |   |
| Normal cycle: | Date of positive pregnancy test: |
| Previous Obstetric history: |
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|
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| Current problem:  |
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|
|
| 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**

EPU Team October 2020