ABORTION REFERRAL
UW MEDICAL CENTER

REFERRAL FAX: 206-598-3966 CLINIC PHONE: 206-597-0040	**Please ensure all OB and relevant medical, genetic records are in Care Everywhere or attached and faxed with this referral.**

Patient Name (Last Name, First Name, Middle Initial)	Date
Gender ☐ Female ☐ Male	Patient preferred language for healthcare communication
Date of Birth	Patient Telephone
Patient Home Address	
Patient Insurance Company and Plan(s)	

Referral From:

Referring Provider Name (Last Name, First Name, Middle Initial)	NPI
Referring Provider Contact Telephone	Referring Provider Fax
Referring Provider Address	
Patient's Primary Care Provider (Last Name, First Name, Middle Initial)	

Reason for Referral:

☐ Patient had abortion options counseling ☐ Induction ☐ Procedure ☐ Unknown

EDD _____

BMI _____

☐ Fetal Anomaly
☐ High Risk Medical Complications: Presence of Maternal Medical Condition
☐ Venous Access Issues
☐ None of the above

PROVIDER SIGNATURE	PRINT NAME AND TITLE	DATE	TIME

PLACE PATIENT LABEL HERE