family planning nsw
Reproductive & Sexual Health

ABORTION REFERRAL FORM

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

Surgical abortion available up to 12weeks 6days gestation
Medical abortion available up to 9weeks 0days gestation
FPNSW will arrange an assessment visit prior to abortion provision appointment.

REFERRAL DETAILS	
Date of Referral	
Type of abortion	

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

REFERRING DOCTOR		
Name		
Practice address		
Phone	W:	M:

CLINICAL HISTORY	
First day of last menstrual period	Date:
Gestation	Weeks: Days:
Dating US completed *(US arranged when gestation at least 5w by dates or serum HCG >2000 IU/L)*	☐ Yes ☐ No If YES – attach copy of report
Pathology *(Blood group, haemoglobin and serum HCG will be arranged by FPNSW)*	☐ Yes ☐ No If YES – attach copy of reports
General medical history including allergies and medications	
Any psychosocial considerations	

Referrer Signature: ____ Date: __ /__ /__