family planning nsw
Reproductive & Sexual Health

ABORTION REFERRAL FORM

FAX COMPLETED FORM TO YOUR NEAREST FPNSW CLINIC:
Newington 02 8752 4392 Fairfield 02 9723 0922
Penrith 02 4731 6787 Dubbo 02 6882 3666 Hunter 02 4926 2029

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

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: __ /__ /__