University of Hawaii Women's Options Centers
REFERRAL FORM

Your patient should call the TelAbortion coordinator to schedule a videoevaluation.

The TelAbortion provider will conduct a comprehensive screening to confirm eligibility for the service, however please confirm these basic criteria before referring your patient:

☐ Has access to a device (phone, tablet, computer) with internet connection, a webcam, and a microphone

☐ Lives in HI or is able to have the consult and receive the package in HI

☐ Does not have any contraindications to medical abortion, including:
- IUD in place
- Chronic adrenal failure
- Inherited porphyrias
- Concurrent long-term corticosteroid therapy
- History of allergy to mifepristone, misoprostol, or other prostaglandin
- Hemorrhagic disorders or concurrent anticoagulant therapy

☐ Is less than 70 days' LMP

☐ Is at least 14 years old; if 14-17, parental consent required

Patient Details

_____ _____/_____/_____

Name (First, Last) *DOB (mm/dd/yyyy)*

Complete if known:

LMP: mm____/ dd____/ yy____ G: _____ P:_____

Any known medical problems: _____

Screening tests

Ultrasound report: ☐ Attached ☐ Will fax later/report not received yet

If ultrasound was performed: Date of u/s: mm____/ dd____/ yy____

Gestational age on date of u/s: _____ days

Rh typing: ☐ Attached ☐ Will fax later/report not received yet

*If Rh type obtained from blood donor card or other written documentation, note source of information:*_____

If Rh typing done: Date of test: mm____/ dd____/ yy____

Rh type: ☐ Positive ☐ Negative

Hemoglobin and Hematocrit (Hgb/Hct) report:

☐ Attached ☐ Will fax later/report not received yet

If Hgb/Hct test was performed: Date/result of test: mm____/ dd____/ yy____

Hgb: _____g/dl Hct: _____%

Referring provider information

_____

Name (First, Last) *e-mail address*

_____

Street address (Street, State, Zip Code)

_____

Phone number *Fax number*

The TelAbortion provider (University of Hawaii/UH) will have a medical abortion consultation with your patient by videoconference. If the patient is eligible, UH will mail the medications and will conduct a follow-up assessment. UH may engage your support if and when necessary. You may contact the site investigator at UH by phone (808) 375-3785, fax (888) 971-7137, or email whrc@ucera.org.

I confirm that all the information I have provided on this form and the medical records I provide to UH are accurate and complete. I have received permission from my patient to share this information with the TelAbortion provider.

_____ _____/_____/_____

Signature Date (mm.dd.yyyy)