

**Referral**  
**Recurrent Pregnancy Loss Clinic**  
 BC Women's Hospital  
 Phone: (604) 875-3706  
 Fax: (778) 504-9762

**Appointment will be given directly to the patient**

Date: \_\_\_\_\_

Name	Pronouns	<input type="checkbox"/> New patient <input type="checkbox"/> Re-referral. Reason: _____
DOB	PHN	
Address	Referring Provider name: _____	
City & Postal Code	Billing # : _____	
Email	Consent to Email	cc: _____
	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Phone Number	Alternate	cc: _____
Primary		
Pregnancy History		cc: _____
G_____T_____P_____SA_____TA_____E_____L_____		
Identify as Indigenous	<input type="checkbox"/> No <input type="checkbox"/> Yes	Language barrier
		<input type="checkbox"/> No <input type="checkbox"/> Yes Language Spoken _____

**Please note that:**

- A large number of losses are due to **random aneuploidy** (abnormal number of chromosomes) in the embryo.
- We recommend **cytogenetic testing** at the time of 2nd and subsequent pregnancy loss.
- **Unexplained pregnancy loss refers to a pregnancy proven to be 46XX /46XY or where karyotype was not obtained.**

**Reason for Referral**

- ≥ 2 consecutive unexplained pregnancy losses at ≤10 weeks gestation
- ≥ 1 unexplained pregnancy loss ≥ 10 weeks and ≤ 20wks gestation by U/S
- Patients with ≥ 1 documented unexplained pregnancy loss at any gestational age **WITH**:
  - Chronic histiocytic intervillitis *OR*
  - Known anti-phospholipid syndrome *OR*
  - Suspected major uterine anomaly (*includes fibroids and adenomyosis, excludes arcuate uterus*) *OR*
  - Known parental translocation

Done	Not Done	Send copies of the following if available:
<input type="checkbox"/>	<input type="checkbox"/>	Consultation with summary of each pregnancy
<input type="checkbox"/>	<input type="checkbox"/>	Ultrasounds with confirmation of pregnancy
<input type="checkbox"/>	<input type="checkbox"/>	Ultrasounds with confirmation of demise
<input type="checkbox"/>	<input type="checkbox"/>	HCG levels if pregnancy not seen in ultrasound (pregnancy of unknown location)
<input type="checkbox"/>	<input type="checkbox"/>	Blood type
<input type="checkbox"/>	<input type="checkbox"/>	Surgical Pathology
<input type="checkbox"/>	<input type="checkbox"/>	Karyotype of the loss (If pending, referral is declined and re-referral is required once criteria met)
<input type="checkbox"/>	<input type="checkbox"/>	HSG or hysteroscopy or other anatomic evaluation
<input type="checkbox"/>	<input type="checkbox"/>	Parental karyotypes
<input type="checkbox"/>	<input type="checkbox"/>	TSH, Prolactin, HbA1C
<input type="checkbox"/>	<input type="checkbox"/>	Anti-cardiolipin antibody, Lupus Anticoagulant antibody, B-2 Glycoprotein antibody
<input type="checkbox"/>	<input type="checkbox"/>	Other:

**Please note:**

\*As of October 2019, patients that are currently pregnant, have previously completed negative RPL work-up, or are undergoing Assisted Reproductive Technology will no longer be accepted as new referrals.

\*We are unable to provide early Pregnancy Monitoring for patients living outside of the Lower Mainland. Referring Providers will be responsible for monitoring their patients with advice available from the RPL clinic.

**Incomplete Referrals will not be accepted**