nova scotia health authority

Gestational Trophoblastic Disease Referral Form

Please mail, email or fax referral to:

Bettina Bentley RN BN, GTD Coordinator Room 5007, 5820 University Avenue Halifax, NS B3H 1V7	Tel:(902)4737434 Fax:(902)4737765 Email:Bettina.bentley@nshealth.ca
Patient: Name: HCN: DOB:	Address: Phone: Cell phone: Email address:
Referring Physician: Name: Address:	**Family Physician:** Name: Address:
Obstetric History: G: P: Date of evacuation: LMP date prior: Gestational Age: Uterine size: Previous molar pregnancy: Yes / No	**Events leading to diagnosis:** (please circle) PV bleeding Ultrasound Recurrent bleeding post abortion histology report Large for dates Small for dates Missed abortion Incomplete abortion Termination Fetal anomality Ectopic pregnancy Evacuation of uterus Increased hCG
Evacuation method: (please circle) Spontaneous D&C (sharp) Hysterectomy D&C (suction) Manual evacuation Hysterotomy Misoprostol used prior to evacuation? Yes / No Was diagnosis suspected prior to evacuation? Yes / No	
D&C done for: (please circle) • Suspect mole • Therapeutic Abortion • Incomplete Abortion • Missed Abortion • Repeat D&C?: Yes/ No ○ If yes date:	Initial Pathology: (please circle) • Complete mole • Partial mole • Invasive mole • Choriocarcinoma • PSTT • other
Following receipt of referral the patient will be contacted directly and appointment made if appropriate.	
Signature:	Date:
Physician:	**Note: Please attach a copy of the pathology report**