UNC Complex Family Planning Referral Form

To facilitate prompt scheduling, please complete this form fully and also attach:

1. Demographic information
2. Legible copy of insurance card front/back
3. Pertinent medical records (with blood type and Ab screen if possible)

Patient Name: (Last, First, MI) ____
Date of Birth: _________________________ Age:______ Medical Record Number: __________________________
Patient Phone#: _______________________ Preferred Language:__________________ Interpreter Needed: Y/N
Number of Fetuses____ LMP/EDD________ Requested timeframe for appointment: ______ (days) _____ (weeks)
Requesting Provider:______________________________ Phone #__________________ Fax# _________________

INDICATION(S) /DIAGNOSIS CODE(S): ____

Consult for Surgical Management of Miscarriage

Required documentation to schedule:

☐ Blood type and AB screen
☐ Most recent ultrasound – report and images if available

Consult for Sterilization (Tubal Ligation)

Reason for referral:

☐ Did not receive PPBTL at delivery (provide details):____
☐ Requests elective sterilization

Required documentation to schedule:

☐ If Medicaid then consent needs to be attached to the referral

Consult for Surgical Management of Pregnancy Complication

Reason for referral:

☐ Maternal health:________________________________
☐ Fetal condition:_________________________________
☐ Diagnosis code(s) if known:_______________________

Patient certain she wishes to proceed with surgical management: Yes/No

Required documentation to schedule:

☐ Blood type and AB screen
☐ Most recent ultrasound – report and images if available

Consult for Removal of Non-Palpable Contraceptive Implant

Required documentation to schedule:

☐ Brand of implant:______________________
☐ Date of implant placement:______________
☐ X-ray of the arm with the implant in
☐ X-ray images and/or report need to be available at the time of consult

Consult for Removal of IUD With No Visible Strings

Required documentation to schedule:

☐ Brand of IUD:______________________________
☐ Date of IUD placement:______________________
☐ Pelvic ultrasound to determine IUD placement
☐ Findings:__________________________________
☐ Ultrasound images and/or report need to be available at the time of the consult

UNC Complex Family Planning Clinic Location:

UNC Hospitals Hillsborough Campus
430 Waterstone Dr
Hillsborough, NC 27278

Scheduling: 984-974-8955
Fax: 984-974-8910

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