Referral letter

Name: .....

Date of birth: .....

Country: .....

Telephone number: .....

Email address: .....

referral for: □ Consultation □ Termination of pregnancy

Weeks amenorrhea: .....

First day last period: .....

Date of referral letter and/or ultrasound: .....

Biparietal diameter: ..... Femur length: .....

Height: ..... Weight: .....

blood type, rhesus factor: □ positive □ negative □ unkown

Medical details:

.....

.....

referring medical doctor, name and contact details:

.....

.....

.....

Date:

Signature medical doctor:

For more information, go to: abortuskliniek-amsterdam.nl or bloemenhove.nl
Call for appointments: **+31 20 6932151 (Amsterdam) of + 31 23 5289890 (Heemstede)**