A black background with white text

Description automatically generated

**Termination of pregnancy (TOP) referral form**

**(for both medical and surgical terminations)**

**Referral process:**

Email your referral and HSA1 form to: [counsellingclinic.enh-tr@nhs.net](https://web.nhs.net/OWA/redir.aspx?SURL=DoVgyYKuJF6OGCxuSDoWo73798Y3bzQYiQuiHcZbpeXkY0p-9cPSCG0AYQBpAGwAdABvADoAVQBTAEUAUgBOAEEATQBFAC0AYwBvAHUAbgBzAGUAbABsAGkAbgBnAGMAbABpAG4AaQBjAC4AZQBuAGgALQB0AHIAQABuAGgAcwAuAG4AZQB0AA..&URL=mailto%3aUSERNAME-counsellingclinic.enh-tr%40nhs.net)

or

Call the team (send HSA1 form with patient): 01438 286190 Woodlands Unit

**Please include the HSA1 form (abortion act) with your referral or send the HSA1 form with the patient**

|  |  |
| --- | --- |
| **Patient Surname:** <Patient Name> | **Date of Birth:**<Date of Birth> |
| **Patient Forename:**<Patient Name> | **Title:** <Patient Name> |
| **Date of referral:** <Today's date> | **GP Name:** <GP Name> |
| **Address:**  <Patient Address> | **GP Address:**  <GP Details> |
| **NHS Number:** <NHS number> | **Last Menstrual period:** |
| **Telephone Number:(Most recent)**  <Patient Contact Details> | **Smokes:**  <Diagnoses>, <Numerics> |
| **Mobile Number:**  <Patient Contact Details> | **Ethnicity:**<Ethnicity> |
| **Medical History:**    <Problems>  <Summary> | |

|  |  |
| --- | --- |
| **Medication:** Acutes | <Medication> |
| Repeats | <Repeat templates> |
| **Allergies:** <Allergies & Sensitivities> | |

**Further information**

The counselling clinic is held in the Woodlands Clinic at Lister Hospital, every Thursday afternoon

We aim to see all referrals within a week in the counselling clinic.

For medical management it will be possible to commence treatment when seen in the clinic.

For medical TOP we can accept patients up to 18 weeks and for surgical up to 12 weeks gestation.

We will contact the patient to confirm the appointment in the counselling clinic – please ensure all telephone numbers are correct.

Woodlands Unit: [counsellingclinic.enh-tr@nhs.net](https://web.nhs.net/OWA/redir.aspx?SURL=DoVgyYKuJF6OGCxuSDoWo73798Y3bzQYiQuiHcZbpeXkY0p-9cPSCG0AYQBpAGwAdABvADoAVQBTAEUAUgBOAEEATQBFAC0AYwBvAHUAbgBzAGUAbABsAGkAbgBnAGMAbABpAG4AaQBjAC4AZQBuAGgALQB0AHIAQABuAGgAcwAuAG4AZQB0AA..&URL=mailto%3aUSERNAME-counsellingclinic.enh-tr%40nhs.net)  February 2024

**IN CONFIDENCE CERTIFICATE A**

**ABORTION ACT 1967**

**Not to be destroyed within three years of the date of operation**

**Certificate to be completed before an abortion is**

**performed under Section 1(1) of the Act**

**I,** **<Sender Name>,**

(Name and qualifications of practitioner in block capitals)

**of** **<Sender Details>, <Sender Address>**

(Full address of practitioner)

**Have seen and examined the pregnant woman to whom this certificate relates at;**

**<Sender Details>, <Sender Address>**

(Full address of place at which patient was seen or examined)

**on** **<Today's date>**

**and I**.......................................................................................................................................................................................................................................

...................................................................................................................................................................................................................................................

(Name and qualifications of practitioner in block capitals)

**of**..............................................................................................................................................................................................................................................

...................................................................................................................................................................................................................................................

(Full address of practitioner)

**Have/have not\* seen/and examined\* the pregnant woman to whom this certificate relates at;**

...................................................................................................................................................................................................................................................

...................................................................................................................................................................................................................................................

(Full address of place at which patient was seen or examined)

**on** **/****/**

**We hereby certify that we are of the opinion, formed in good faith, that in the case**

**of <Patient Name>, NHS Number: <NHS number>**

(Full name of pregnant woman in block capitals)

**of** **<Patient Address>**

(Usual place of residence of pregnant woman in block capitals)

(Tick A  the continuance of the pregnancy would involve risk to the life of the pregnant woman greater

appropriate than if the pregnancy were terminated;

letter(s))

B  the termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman;

C  the pregnancy has NOT exceeded its 24th week and that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman;

D  the pregnancy has NOT exceeded its 24th week and that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of any existing child(ren) of the family of the pregnant woman;

E  there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.

**This certificate of opinion is given before the commencement of the treatment for the termination of pregnancy to which it refers and relates to the circumstances of the pregnant woman's individual case.**

**Signed:**  **Date:** <Today's date>

**Signed:**  **Date:** …………………………………………………

\* Delete as appropriate DdDH005329 4/94 C8000 CC38806 Form HSA1 (revised 1991)