GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Caerdydd a'r Fro | Cardiff and Vale University Health Board

Outpatient Medical Management of Miscarriage

EPAU Integrated Care Pathway

(Patient's Identifying Label)

Date:__________
Gestation by dates __________
Gestation by scan (if different) __________

Consent form signed	
Patient information leaflet and emergency contact numbers given	
Discussed pain relief and need for access to support (partner, friend)	
Explain need for repeat pregnancy test in 3 weeks	
Name and Signature of Clinician/Practitioner	

<table>
<tr><td rowspan="2">Drug Allergies THIS SECTION MUST BE COMPLETED</td><td>☐ YES
Specify Drugs____________________
Allergy Details________________
Signature_______________ Date____________</td><td rowspan="2">Patient weight: .... Kg
Requires thrombo-embolic prophylaxis?
YES / NO
Details...
....
....
____
Signature of Assessor</td></tr>
<tr><td>☐ NONE KNOWN
Signature___________________ Date__________</td></tr>
</table>

Date	MEDICINE (approved name)	DOSE (depending on weight)	ROUTE	PRESCRIBER signature	DISPENSED by (date and time)	CHECKED by (date and time)
	Mifepristone	200mg	PO			
	Misoprostol	800 micrograms	PV or Buccal			
	Misoprostol	400 micrograms	Buccal			