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

Early Pregnancy Assessment Unit

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	

Drug Allergies THIS SECTION MUST BE COMPLETED

YES ☐

Specify Drugs _____

Allergy Details _____

Signature _____

Date _____

NONE KNOWN ☐

Signature _____

Date _____

Patient weight: _____ Kg

VTE score _____

Requires thrombo-embolic prophylaxis?

YES ☐ NO ☐

Details _____

Signature of Assessor .

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			