National Maternity Hospital
Ambulatory Gynaecology Clinic referral form

PATIENT DETAILS

Name :

Address:

Phone no: **DOB:**

REFERRAL SOURCE

GP ☐
INTERNAL ☐
OTHER HOSPITAL ☐

Name of refering Dr: _____

REFERRAL INDICATION

Post-menopausal bleeding ☐
Menstrual irregularity age 45+ ☐
IUD retrieval ☐
Endometrial polyp/intracavity fibroid ☐

CLINICAL DETAILS

PARITY	☐	VAGINAL EXAMINATION FINDINGS:	
VAGINAL DELIVERIES	YES / NO	CONTRACEPTION	_____
SMEARS UP TO DATE & NORMAL	YES / NO	HRT	YES / NO
SUITABLE FOR TRANSVAGINAL PROCEDURE	YES / NO	ANTICOAG USE	YES / NO
PAST HISTORY OF LLETZ / CONE BIOPSY	YES / NO	PHYSICAL DISABILITY	YES / NO
BMI	☐	INTERPRETER NEEDED	YES / NO
RECENT Hb	☐	PELVIC U/S DONE	YES / NO
		Please attach report	

If the patient is interested in a Mirena coil / other IUD it may be possible to insert at time of visit.**Please ask patient to bring a Mirena / IUD with her.**

Please send completed referral form to The Outpatient Hysteroscopy Clinic at The National Maternity Hospital

_____ _____

TRIAGED BY DR. DATE PLAN