The National Maternity Hospital

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Ambulatory Gynaecological Clinic Referral Form

PLEASE ENSURE FORM IS FULLY COMPLETED OR REFERRAL WILL NOT BE ACCEPTED

Patient Details	**Referral Source**
Name: NMH MRN: DOB: Address: Phone Number: Please state language / ISL if Interpreter required:	GP ☐ Internal ☐ Other Hospital ☐ DATE OF REFERRAL: **Name and of Referring Consultant / Clinic /Practice:**

Referral Indication

Post –menopausal bleeding ☐
Menstrual irregularity age 45+ ☐
Endometrial polyp /intracavity fibroid (please circle) ☐
IUD retrieval ☐
Fertility investigation ☐

Further relevant Info (please ensure below information also completed):

Please confirm this patient is aware of referral: YES ☐

Clinical Details

Parity ☐

Vaginal Deliveries Yes ☐ No ☐

Smears up to Date & Normal Yes ☐ No ☐

Suitable for Transvaginal Procedure Yes ☐ No ☐

Past History of LLetz/Cone Biopsy Yes ☐ No ☐

BMI ☐

Recent Hb ☐

Pelvic U/S Done Yes ☐ No ☐ **(Please attach report)**

Vaginal Examinations Findings:

_____

_____

_____

Contraception or Form of HRT and length of use:

_____

HRT	Yes ☐	No ☐
Anticoag Use	Yes ☐	No ☐
Physical Disability	Yes ☐	No ☐
Interpreter Needed	Yes ☐	No ☐

Please tick if awaiting scan locally ☐

If 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, email gynaeCRO@nmh.ie. Please ensure all relevant investigations/reports are attached.

Triaged by Hysteroscopy Consultant _____ Date: _____

Plan