The National Maternity Hospital

GP REFERRAL FORM FOR COMPLEX MENOPAUSE SERVICE

Information for GPs and Referring Doctors

The Complex Menopause Service is accepting referrals on patients with an address within the Ireland East Hospital Group catchment area including **- South Dublin, Carlow, Kilkenny, South Tipperary, Waterford, Wexford and Wicklow that have a past or current diagnosis of:**

- **Active Liver disease**
- **Cancer**
- **Coronary Heart Disease**
- **Epilepsy**
- **Immunological diseases**
- **Premature Ovarian Insufficiency**
- **Stroke**
- **Venous thromboembolism**

To assist us in triaging this appointment appropriately, we ask that you please complete the form fully and kindly provide the following:

- Recent blood test results including - FBC, Fasting lipids and glucose, TFT and any other results relevant to your patient's condition
- Relevant correspondence from Specialist Consultants
- If referring for Premature Ovarian Insufficiency consultation you must provide us with two FSH results at least 4 weeks apart

We are unable to triage your patient for an appointment without all the relevant information. Incomplete referrals will be rejected.

We thank you for your cooperation

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PATIENT DETAILS:

Patient Name:	
Patient Address:	
Next of Kin name:	
Next of Kin address:	
Date of Birth:	**Contact Telephone:**
Age at referral:	**Contact Email:**

Please tick which co-morbidity applies to this referral:

Active Liver disease	
Cancer	
Coronary Heart Disease	
Epilepsy	
Immunological disease	
Premature Ovarian Insufficiency	
Stroke	
VTE	

REFERRER DETAILS:

Name of Referring Doctor:
Patients GP (if different):
Address:
MCRN:
Contact telephone no of referring doctor:
Date of referral:

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REFERRAL DETAILS

Current most troublesome menopausal symptoms
Details of any previous/current HRT or non-hormonal treatment for symptoms

Gynaecological History	
Parity:	**LMP:**
Cervical Screening:	
Current Menstrual Pattern:	

Additional Medical History	
Smoker ☐ **Non-Smoker** ☐	**BMI:**
Blood Pressure: must be normotensive/ adequately controlled before referral	
Known Allergies:	

Current Medication:

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DETAILS OF MEDICAL DIAGNOSIS

Comorbidities:
Details of Diagnosis to date including Surgeries and Treatments

Additional information
Please include COPIES OF COMMUNICATIONS FROM SPECIALITY CLINIC **<u>Recent</u> general blood tests including: FBC, TFT, Lipids, Glucose, HbA1c (& any other surveillance serology relevant to the patient's condition)**

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