 **Gynaecology Referral Form**

**The Royal Women’s Hospital**

**Fax referral to: 8345 3036**

Do not fax if considering TOP – please provide referral to patient and ask her to Phone 1800 My Options on P: 1800 696 784

Dear Dr

As the Women’s hospital health services operate mixed outpatient clinics, we request all referrals be addressed to a named medical practitioner. This enables us to provide patients with the choice of being treated as either a private or public patient.

**Patient Details**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| First Name |  | Last Name |  | Previous RWH patient  | ❒ Yes ❒ No |
| Date of Birth |  | Medicare Number |  | Exp. Date |  |
| Address | Health Insurance Fund |
| Suburb |  | Postcode |  | Health Insurance Number |
| Home Phone |  | Mobile |  | ATSI  | ❒ Yes ❒ No  |
| Interpreter required? | ❒ Yes ❒ No | Disability or special needs | ❒ Yes ❒ No  | Specify |
| Language | Country of birth |

**Referring Doctor**

|  |  |  |  |
| --- | --- | --- | --- |
| Print Name |  | Provider Number |  |
| Practice Address | Suburb | Postcode |
| Phone |  | Fax |

**Reason for Referral / Diagnosis** *Please provide significant symptoms, signs, investigation results and any reasons that identify a need for early hospital assessment. If there is insufficient information, triaging will be delayed*

**BMI:** ❒  **<35** ❒ **> 35**

**Relevant co-morbidities / past medical / psychiatric / genetic / family history**

**Other Relevant Information**

**Medicines**

**Allergies**

**Investigation Results** *Please attach all relevant investigation results to assist us to triage correctly*

Pathology Provider \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Radiology Provider \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tests attached

|  |  |  |  |
| --- | --- | --- | --- |
| FBE | ❑  | Tumour markers | ❑  |
| Ferritin | ❑  | Hormonal studies  | ❑  |
| TFTs | ❑  | Coagulation profile | ❑  |
| MSU  | ❑  | Pap smear | ❑  |
| Swabs | ❑  | Pelvic ultrasound | ❑  |
|  |  | Mammogram | ❑  |

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| **Doctor’s Signature:** |  | **Date:** |  |

**Appointment details will be sent to referring GP and patient**

Referrals are triaged by a clinician based on the patient’s residential address proximity to the Women’s and the anticipated need for tertiary level care

Guidance is assessing, managing and referring some problems can be found on the <https://www.thewomens.org.au/wm-scguide> and <https://melbourne.healthpathways.org.au>

Please encourage your patient to link to their https://myhealthrecord.gov.au/internet/mhr/publishing.nsf/Content/appconnectvia a phone app as its capability to upload pathology & imaging reports is increasing