AMBULATORY HYSTEROSCOPY CLINIC
REFERRAL FORM

Please note that this clinic is for patients requiring outpatient diagnostic and operative hysteroscopy only.
Email: apptscheduling@rotunda.ie **Fax No:** 01-8172514 **Office:** 087 1870581
Post To: Central Appointments Office, Rotunda Hospital, Parnell Sq., Dublin 1

Internal Referrals: please use Rotunda addressograph label below:

Patient Name:

Date of Birth:
Address:

Phone:
Mobile:
Private health insurance: Y/N
Medical card: Y/N

Source of Referral: General Practitioner/Hospital Consultant/Other (please circle)

Name:
Medical Council No:
GP Address:

S.o.R Phone:
Date of referral:

REASON FOR REFERRAL

POSTMENOPAUSAL

- Postmenopausal bleeding []
- Abnormal Ultrasound (attach report/ outline) []
  _____
  _____
  _____
- Smear with endometrial pathology []**
  _____
- Other (please outline) []
  _____

PREMENOPAUSAL

- Abnormal Uterine Bleeding*
  - Mennoraghia []
  - IMB []
- Abnormal Ultrasound []
  _____
  _____
  _____
- Smear with endometrial pathology []**
  _____
- Investigation of infertility []
- Other (please outline)
  _____

**Patient under 45yrs should be referred to gynaecology clinic unless there is clear indication for hysteroscopy.*
***Should be referred to colposcopy clinic first. Decision for ambulatory hysteroscopy will be made by colposcopist.*

SUSPECTED PATHOLOGY/ PATHOLOGY YOU WISH TO OUTRULE OR TREAT
(Tick all that applies)

- Endometrial Hyperplasia []
- Endometrial Cancer []
- Endometrial/ Endocervical Polyp []
- Fibroid []
- Septum []
- Other (Please outline) []
  _____
  _____

Official Use:

Accept: Routine []
Urgent []

Decline []
Redirect to: _____