**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:** 01 817 2514 **Office:** 087 187 0581

**Post to:** Central Appointments Office, Rotunda Hospital, Parnell Sq, Dublin 1

# INTERNAL REFERRALS: PLEASE USE ROTUNDA ADDRESSOGRAPH LABEL BELOW:

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

Name:

Medical Council No:

GP Address:

S.O.R. Phone:

Date of referral:

Patient Name:

Date of Birth:

Address:

Phone:

Mobile:

Private health insurance: Yes/No

Medical card: Yes/No

Interpreter Needed: Yes/No

**REASON FOR REFERRAL**

**POSTMENOPAUSAL**

* Postmenopausal bleeding
* Abnormal Ultrasound (attach report/outline)
* Smear with endometrial pathology\*\*
* Other (please outline)

# PREMENOPAUSAL

* Abnormal Uterine Bleeding\*
	+ Menorrhagia
	+ 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.*

***Please ensure that your patient has a Mirena® coil if she wishes to have it inserted on the day***

# ADDITIONAL RELEVANT INFORMATION:

**SUSPECTED PATHOLOGY/ PATHOLOGY YOU WISH TO OUTRULE OR TREAT**

(Tick all that applies)

* Endometrial Hyperplasia

*Official Use:*

*Accept: Routine*

*Urgent*

*Decline*

*Redirect to:*

* Endometrial Cancer
* Endometrial/ Endocervical Polyp
* Fibroid
* Septum
* Other (Please outline)