AMBULATORY HYSTEROSCOPY CLINIC

REFERRAL FORM

Email: ophwl@rotunda.ie **Phone:** 087 1870581
Post To: Hysteroscopy Clinic, Rotunda Hospital, Parnell Sq., Dublin 1

Patient Name:	**Source of Referral:** General Practitioner/Hospital Consultant/Other (please circle)
Date of Birth: **Address:**	**Name:** **Medical Council No**: **GP Address:**
Phone:	**S.o.R Phone:**
Private health insurance: Y/N **Medical card: Y/N**	**Date of referral:**

Patient Information:

Age: Parity: Medical/Surgical History:

Medications:

Allergies:

REASON FOR REFERRAL :

POSTMENOPAUSAL

- Postmenopausal bleeding []

On HRT: Yes/No
HRT type:

- Abnormal Ultrasound (attach report/ outline) []

_____
_____
_____

- Other (please outline) []

_____
_____

PREMENOPAUSAL

- Abnormal Uterine Bleeding*
  Menorrhagia [] IMB []

- Abnormal Ultrasound (attach report/ outline) []

_____
_____
_____

- Investigation of infertility []
- Other (please outline) []

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**Patient under 45yrs should be referred to gynaecology clinic unless there is clear indication for hysteroscopy.*
Note: Smear with endometrial pathology should be referred to colposcopy clinic first. Decision for ambulatory hysteroscopy will be made by colposcopist.

Official Use:

Accept: Routine []
Urgent []

Decline []
Redirect to: _____