

GYNAECOLOGY OUTPATIENT CLINICS – The Sutherland Hospital

Patients to bring Medicare card and Ultrasound report if they have one.

Please send GP Referral to either fax: (02) 9540 7304

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Gynaecology Clinic									
	Menorrhagia 🗆		Uterine Fibroid 🗆		PV Bleeding				
	Endometrial Polyp		Ovarian Cyst Irregular Menst Periods		Irregular Menstrual Periods				
	Cervical Polyp		Subfertility		Infertility				
	Mixed gynaecological symptoms								
□ Implanon and Mirena insert or removal									
Colposcopy Clinic									
	Abnormal cervical screening results that require colposcopy								
	Post coital bleeding								
Menopause Clinic									
	Menopause problems								
NB:	For uterine prolapse or stress incontinence problem refer to Pelvic Floor Bladder Unit on (02) 9113 2272								



Sutherland Hospital Gynaecology Outpatients Clinic

Patient Referral Form

Referral received:												
Referral received:												
Referren notified of receipt:	Outpatient Clinic use only					Referral to:						
Patient details	Referral receive	/										
Title: Mr	Referrer notifie	d of receipt:	/	/								
Title: Mr												
Mr Mrs Ms Miss Post Code: Suburb: Post Code: Medicare number: Date of birth: / / / Sex/gender: M (male) F (female) X (indeterminate/intersex/unspecified) M (male) F (female) M (male) M (male)	Patient details	3										
Address: Suburb: Post Code:	Title:			Surname:			First Name:					
Suburb: Post Code: Medicare number: Date of birth: / / / / / / / / / / / / / / / / / / /	Mr □ Mrs □] Ms □ Miss □										
Medicare number: Date of birth: Date of birth: / / / / / / / / / / / / / / / / / / /	Address:											
number: birth: birth: Sex/gender: M (male) □ F (female) □ X (indeterminate/intersex/unspecified) □ Compensable status DVA □ WorkCover □ Motor Vehicle □ Third Party Insurance □ Other □ Phone: W (work) H (home) M (mobile) M (mobile) Email: Communication preference: Phone W □ Phone H □ Phone M □ Email □ Special needs/reasonable adjustments required for disability: Yes □ No □ Interpreter required: Language: Yes □ No □ Description: Description: Carer name (if appropriate): GP name (if not referrer): Test = Third Party Insurance □ Other □	Suburb:					Po	Post Code:					
Compensable status DVA												
Status DVA	Sex/gender:	M (male) ☐ F (female) ☐					X (indeterminate/intersex/unspecified) \square					
Email: Communication preference: Phone W Phone H Phone M Email Identifies as of Aboriginal or Torres Strait Islander origin: Yes No Special needs/reasonable adjustments required for disability: Interpreter required: Language: Carer name (if appropriate): GP name (if not referrer):		DVA ☐ WorkCover ☐ M				otor	tor Vehicle □ Third Party Insurance □ Other □					
Phone W □ Phone H □ Phone M □ Email □ Identifies as of Aboriginal or Torres Strait Islander origin: Yes □ No □ Special needs/reasonable adjustments required for disability: Interpreter required: Language: Carer name (if appropriate): GP name (if not referrer):	Phone:	W (work) H (home)				M (mobile)						
Identifies as of Aboriginal or Torres Strait Islander origin: Interpreter required: Language: Carer name (if appropriate): Yes No Special needs/reasonable adjustments required for disability: Description: GP name (if not referrer):	Email:						Communication preference:					
Strait Islander origin: Yes \(\begin{array}{cccccccccccccccccccccccccccccccccccc							Phone W ☐ Phone H ☐ Phone M ☐ Email ☐					
Yes ☐ No ☐ Description: Language: Carer name (if appropriate): GP name (if not referrer):				Yes 🗆 No 🗆			adjustments required for		Yes 🗆	No 🗆		
Language: Carer name (if appropriate): GP name (if not referrer):	Interpreter required:			Yes □ No □			Description:					
Phone: Phone/email:	Carer name (if appropriate):						GP name (if not referrer):					
							Phone/email:					
Email: Address:	Email:						Address:					



Clinical details

Reason for referral: (including presenting symptoms -onset, duration and severity, if appropriate - and physical findings)							
Any previous treatment or investigations for referral condition:	Yes 🗆	Description: (please attach	h investigation outcomes)				
Any previous surgery: Yes Description			i:				
Any other co-existing conditions:	Yes 🗌		No C				
Any current medication: (including any allergies) Yes Description			and dosage:				
Referrer details							
Name:			GP □	Other			
Provider number:			Phone:				
Email:			Fax:				
Signature:			Date:	1 1			
Other details if required							