

GYNAECOLOGY OUTPATIENT CLINICS – ST GEORGE HOSPITAL

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

Please send GP Referral to either fax: (02) 9113 3765 or email to:

SESLHD-StGeorge-GynaeClinic@health.nsw.gov.au

Gynaecology Clinic

- Menorrhagia
- Uterine Fibroid
- PV Bleeding
- Endometrial Polyp
- Ovarian Cyst
- Irregular Menstrual Periods
- Cervical Polyp
- Subfertility
- Infertility
- Mixed gynaecological symptoms
- Implanon insert or removal

Hysteroscopy Clinic

- Endometrium Thickening
- Mirena insertion (BYO) or removal
- Multi-load IUD (Copper IUD) insertion
- IUD 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

**ST GEORGE HOSPITAL
WOMEN'S AND CHILDREN'S
PATIENT REFERRAL TO GYNAECOLOGY
OUTPATIENT SERVICE**



Health
South Eastern Sydney
Local Health District

Level 1, Prichard Wing – St George Hospital
Gynaecology Tel: (02) 9113 2162 Fax: (02) 9113 3765
Email: SESLHD-StGeorge-GynaeClinic@health.nsw.gov.au

Referral to: Professor M. Chapman, Dr T. Miller, Dr C. Krishnan, Dr G. Davis, Dr D. Rosen, Dr S Chwah,
Dr M. Damasco, Dr L. Collins, Dr E. Chesterman, Dr K. Kavanagh-Patel, Dr J. Robertson

Patient Surname: _____ First Name: _____

DOB: _____

Address: _____

Phone Number: _____ Mobile: _____

Email: _____

Medicare No:																					Medicare Expiry Date://.....
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Note: include patient's reference number as the eleventh number of the Medicare card

INTERPRETER REQUIRED: YES/NO Dialect: _____

REASON FOR REFERRAL:

MEDICATIONS: _____

Results attached: YES / NO

REFERRING DOCTOR'S SIGNATURE _____ DATE _____

Requesting DR:	
Provider No:	
Telephone:	
Address:	

Please complete this section in full or with practice stamp.