***GYNAECOLOGY REFERRALS***

***Incomplete referrals will be returned.***

***This service is NOT for acutely ill patients or suspected cancer***

***POSTMENOPAUSAL BLEEDING AND ABNORMAL CERVIX SHOULD BE REFERRED AS 2WW***

|  |  |
| --- | --- |
| **Practice information** | **Patient information** |
| Date of GP Consultation:<Todays date> | NHS Number: <NHS number> |
| GP Name: <Sender name> | Patient Surname: <Patient name> |
| Practice Name: <Surgery name> | Patient Forename: <Patient name><Patient name> |
| Address: <Practice Address> | DOB: <Date of birth> |
|  | Ethnicity: <Ethnicity> |
|  | Address: <Patient address> |
| Postcode: <Practice Postcode > | Postcode: <Patient address> |
| Telephone number: <Contact Telephone No> | Telephone number: <Patient contact details> |
| Fax number: <Contact Fax No> | Mobile number: <Patient contact details> |
| NHS email: <Practice NHS.net account> | Email address: <Patient contact details> |
|  | Does patient require interpreter? Yes [ ]  No [ ]  |
| Practice Code: <Practice Code>GP Code: ~<GP details> | If Yes, What Language |
| Referral to:[ ] Gynaecology[ ] Women physiotherapy [ ] Continence |
| **Assessment required from Gynaecology – this form covers referral to community (including physio) and hospital services (excluding 2WW)****Indications for referral (tick box)** **Referral to** |
|  |
| **History of Current Problem/ Examination** (merge last consultation) |
| **For the condition ticked the following information will need to be attached as a minimum** |
|  |
| [ ]  Menorrhagia and Menstrual Disorders | [ ]  USS performed on ………….and report attached[ ]  USS requested at …………...…..(please specify)[ ]  Medication already tried (please specify below) |
| [ ]  Menopausal symptoms (esp. <45yo, diagnostic difficulties, severe symptoms not amenable to HRT) | [ ]  Hormonal blood test attached (if suspected POI)[ ]  Medication already tried (please specify below) |
| [ ]  PCOS | [ ]  Hormonal blood test attached (LH/FSH/testosterone on day 2-5 of cycle if able)[ ]  USS performed on ………….and report attached[ ]  USS requested at …………...…..(please specify)[ ]  Patients BMI is …………...…...(please specify)[ ]  Tick if the patient is trying to conceive |
| [ ]  Pelvic pain | [ ]  USS performed on ………….and report attached[ ]  USS requested at …………...…..(please specify)[ ]  Swabs results attached |
| [ ]  Post coital bleeding  | [ ]  Last Cervical smear …/…/…. report attached[ ]  USS requested at …………...…..(please specify)[ ]  Swabs (inc Chlamydia) results attached |
| [ ]  Urinary incontinence/Prolapse /Pessary fitting | [ ]  MSU in the last 3m report attached[ ]  Medication/input already tried (please specify below)[ ]  USS performed on ………….and report attached |
| [ ]  Vaginal discharge/ Vulval symptoms | [ ]  Last Cervical smear …/…/…. report attached[ ]  Swabs (inc Chlamydia) results attached |
| [ ]  Vaginismus/Psychosexual issues  |   |
| [ ]  Recurrent miscarriage (required for referral to secondary care) | [ ]  >3 first trimester miscarriages[ ]  1 - 2nd trimester and 1 first trimester miscarriage[ ]  Less than 40 years old |
| [ ]  Fertility | [ ]  Baseline D3 FSH/ LH[ ]  Baseline D21 Progesterone[ ]  USS Pelvis report – [ ]  Semen analysis report -  |
| **Other Relevant PMH** |
| Past gynaecological / obstetric history: ~[Free Text: Parity:]Contraception: ~[Free Text: Contraception:]Previous surgery: ~[Free Text: Previous surgery:]Menstrual history: ~[Free Text: Menstrual history:] |
| Past medical history: <Repeat templates(table)> |
| Current medication: ~[Medication]Allergies: ~[Allergies] |
| Suspected diagnosis: |
| GP expectation from referral : [ ]  Diagnosis [ ]  Management [ ]  Other |
| If the patient needs onward referral Does the patient have a preferred hospital?: [ ]  Queen Charlotte’s [ ]  St Mary’s [ ]  Chelsea and Westminster [ ]  Other |

**Exclusion Criteria.**

The service does not see – Under 16s, suspected cancer, Colposcopy referrals, and Early Pregnancy problems – refer direct to secondary care.