***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.