Health
South Eastern Sydney
Local Health District

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

Gynaecology Clinic

□ Menorrhagia	□ Uterine Fibroid	□ PV Bleeding
□ Endometrial Polyp	□ Ovarian Cyst	□ 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

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Sutherland Hospital
Gynaecology Outpatients Clinic

Patient Referral Form

Outpatient Clinic use only	
Referral received:	/ /
Referrer notified of receipt:	/ /

Referral to:

Patient details

Title: Mr ☐ Mrs ☐ Ms ☐ Miss ☐		Surname:		First Name:	
Address:					
Suburb:			Post Code:		
Medicare number:			Date of 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)	
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:	Yes ☐	No ☐
Interpreter required: Language:	Yes ☐	No ☐	Description:		
Carer name (if appropriate):			GP name (if not referrer):		
Phone:			Phone/email:		
Email:			Address:		

NSW GOVERNMENT Health
South Eastern Sydney Local Health District

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 investigation outcomes)	No ☐
Any previous surgery:	Yes ☐	Description:	No ☐
Any other co-existing conditions:	Yes ☐		No ☐
Any current medication: (including any allergies)	Yes ☐	Description and dosage:	No ☐

Referrer details

Name:		GP ☐ Other ☐	
Provider number:		Phone:	
Email:		Fax:	
Signature:		Date:	/ /

Other details if required