Health
South Eastern Sydney
Local Health District

GYNAECOLOGY OUTPATIENT CLINIC – The Sutherland Hospital

Please email referral to:

SESLHD-TSHGYN@health.nsw.gov.au

Please ensure referral includes copy of relevant bloods, pelvic ultrasound and most recent cervical screening test result.

Urgent referrals / clinical advice please call (02) 9540 7111 and ask for pager #125

Fax: (02) 9540 7304 (email preferred)

Patient to please bring Medicare card to appointment

Dr John Breen / Dr Dean Conrad / Dr Amani Harris / Dr Chandra Krishnan

Indication for referral

Abnormal bleeding (HMB, IMB, irregular bleeding)

Colposcopy (abnormal cervical screening test / PCB)

Incontinence

Infertility

IUD insertion/removal

Menopause symptoms

Ovarian cyst

Pelvic pain

Prolapse

Other:

Health
South Eastern Sydney
Local Health District

Sutherland Hospital
Gynaecology Outpatients Clinic

Patient Referral Form

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

Referral to: (clinician's name)

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:		

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 ☐	Description:	No ☐
Any current medication: (including any allergies)	Yes ☐	Description and dosage:	No ☐

Referrer details

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