AMBULATORY HYSTEROSCOPY CLINIC REFERRAL FORM

Please note that this clinic is for patients requiring outpatient diagnostic and operative hysteroscopy only.
Email: apptscheduling@rotunda.ie **Fax No:** 01 817 2514 **Office:** 087 187 0581
Post to: Central Appointments Office, Rotunda Hospital, Parnell Sq, Dublin 1

THE ROTUNDA HOSPITAL DUBLIN

INTERNAL REFERRALS: PLEASE USE ROTUNDA ADDRESSOGRAPH LABEL BELOW:

Patient Name:	**Source of Referral:** General Practitioner/ Hospital Consultant/Other (please circle)
Date of Birth:	
Address:	**Name:**
	Medical Council No:
	GP Address:
Phone:	
Mobile:	
Private health insurance: Yes ☐ No ☐	**S.O.R. Phone:**
Medical card: Yes ☐ No ☐	**Date of referral:**

REASON FOR REFERRAL

POSTMENOPAUSAL

- Postmenopausal bleeding ☐
- Abnormal Ultrasound (attach report/outline) ☐

_____

_____

_____

- Smear with endometrial pathology** ☐

_____

- Other (please outline) ☐

_____

PREMENOPAUSAL

- Abnormal Uterine Bleeding*
  - Mennoraghia ☐
  - IMB ☐
- Abnormal Ultrasound

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_____

_____

- Smear with endometrial pathology** ☐

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- Investigation of infertility ☐
- Other (please outline) ☐

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Patient under 45yrs should be referred to gynaecology clinic unless there is clear indication for hysteroscopy.
***Should be referred to colposcopy clinic first. Decision for ambulatory hysteroscopy will be made by colposcopist.*

ADDITIONAL RELEVANT INFORMATION: _____

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SUSPECTED PATHOLOGY/ PATHOLOGY YOU WISH TO OUTRULE OR TREAT

(Tick all that applies)

- Endometrial Hyperplasia ☐
- Endometrial Cancer ☐
- Endometrial/ Endocervical Polyp ☐
- Fibroid ☐
- Septum ☐
- Other (Please outline) ☐

_____

_____

Official Use:

Accept: Routine ☐
Urgent ☐

Decline ☐
Redirect to: _____