

Endometriosis Referral Form

Patient details

Name: _____

UR (if an existing Epworth patient): _____

Address: _____

Postcode: _____

Telephone: _____ Email: _____

Gender: _____ DOB: / /

Medicare card number: _____ Expiry date: /

Health fund: Yes No Name of fund: _____ Membership number: _____

Department of Veteran Affairs: Gold White Membership number: _____

Next of kin details

Name: _____

Telephone: _____ Relationship to patient: _____

Referrer details

Name: _____ Provider number: _____

Specialist GP Clinic name: _____

Patient's usual GP (if not referrer): _____

Address: _____

Postcode: _____

Telephone: _____ Fax: _____

Email: _____

Endometriosis Referral Form



Reason for referral

- Suspected endometriosis Confirmed endometriosis Pain Fertility Care coordination Other

Additional information:

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History

- Is this patient already known to a gynaecologist? Would they like to see the same specialist again?

Additional information:

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Medical information

Imaging results:

- Pelvic ultrasound:
- MRI:
- Other imaging (if performed):

Please attach any relevant correspondence, imaging, histology or pathology results with this referral.

Details of relevant past medical history, current medications and allergies:

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Other additional information:

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Please email your referral form to our endometriosis nurse coordinator at EHendonurse@epworth.org.au

Julia Argyrou Endometriosis Centre at Epworth

Ground Floor, 185-187 Hoddle Street, Richmond VIC 3121
Phone 03 9516 2434 | Fax: 03 9429 4947
Email EHEndocentre@epworth.org.au