Epworth HealthCare

Endometriosis Referral Form

JULIA ARGYROU
Endometriosis Centre

Epworth

Patient details

Name:

UR (if an existing Epworth patient):

Address:

Postcode:

Telephone: Email:

Gender: Pronouns DOB: / /

Medicare card number: Reference 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:

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Reason for referral

☐ Suspected endometriosis ☐ Confirmed endometriosis ☐ Pain ☐ Fertility ☐ Care coordination ☐ Other

Additional information:

History

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

Additional information:

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:

Other additional information:

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

Julia Argyrou Endometriosis Centre at Epworth

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