Rapid Access Hysteroscopy

GP Referral Questionnaire

To assist us to consider your patient for Rapid Access Hysteroscopy services at the Women’s, please provide the following information with your referral.

|  |  |
| --- | --- |
| Patient details | |
| Patient name |  |
| Patient date of birth |  |
| Patient weight (kg) |  |

**Please indicate if your patient meets any of the below criteria for the Rapid Access Hysteroscopy**

|  |  |
| --- | --- |
|  | Heavy menstrual bleeding |
|  | Postmenopausal bleeding (PMB) |
|  | Retained IUD |
|  | Endometrial polyps <2cm |
|  | Endocervical polyps <2cm requiring Hysteroscopy Dilation and curette |
|  | Thickened endometrium |

**Please indicate if your patient might not be suitable:**

|  |  |
| --- | --- |
|  | Cervical polyps only (likely removed in usual outpatient appointment) |
|  | Likely to need laparoscopy (has pelvic pain) |
|  | Endometrial polyp >2cm |
|  | Insertion of Intrauterine contraceptive device only |
|  | Never sexually active |
|  | Poor tolerance of speculum examination |
|  | Known cervical stenosis |
|  | Significant medical comorbidities |

**Please attach to your referral**