Ambulatory Gynaecology Clinic Referral Form

(AUB/PMB/IUD insertion/Minor procedures)

Email to: zainab.barry@healthmail.ie

Referrer Details

Source of referral: GP / Consultant / Other (please circle)

Name:

Address:

Tel:

Email:

Date of Referral:

Patient Details

Name:

Address:

Tel:

Date of Birth:

Private Health Insurance: Yes ☐ No ☐

Self-Pay: Yes ☐ No ☐

Clinical Information

Allergies:

Medications:

Medical / Surgical History:

Reason for Referral

IUD insertion ☐

Outpatient Hysteroscopy: ☐

(Please provide further information below)

Premenopausal

- Abnormal Uterine Bleeding

  Menorrhagia ☐ IMB ☐
- Abnormal Ultrasound (attach report/outline)
- Other (please outline)

Postmenopausal

- Postmenopausal Bleeding

  On HRT? Yes ☐ No ☐

  If yes, specify type:
- Abnormal Ultrasound (attach report/outline)
- Other (please outline)

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