Epworth HealthCare

Endometriosis Referral Form

JULIA ARGYROU
Endometriosis Centre

Epworth

Are you a patient of an Epworth gynaecologist? ☐ Yes ☐ No

If not, are you willing to see an Epworth gynaecologist? ☐ Yes ☐ No

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

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

www.epworth.org.au/ juliaargyrouendocentre

NP3210_JFPC_1221

IF YOU ARE A PATIENT INTENDING TO ACCESS OUR SERVICES PLEASE FILL OUT THE CONSENT FORM BELOW.

IF YOU ARE A HEALTHCARE PROFESSIONAL REFERRING YOUR PATIENT PLEASE LEAVE THE CONSENT FORM BLANK.

Not for scanning in HIS - return to Endometriosis Centre

CLEAR FORM

Epworth

Julia Argyrou Endometriosis Centre at Epworth
Information Disclosure Consent Form

Affix Patient Identification Label

Surname ....

Given name ....

D.O.B. .... Age .... Sex..........

Address ....

Medical Practitioner ....

☐ I am happy for communication with all health care professionals, or please list all professional supports:

Name:	Role: ☐ GP ☐ Gynaecologist ☐ Psychologist ☐ Pain Specialist ☐ Physiotherapist ☐ Other (please specify): ________
Contact information:	
I consent for the following information to be shared: ☐ All relevant information ☐ Only specific information (please specify): ________	

Name:	Role: ☐ GP ☐ Gynaecologist ☐ Psychologist ☐ Pain Specialist ☐ Physiotherapist ☐ Other (please specify): ________
Contact information:	
I consent for the following information to be shared: ☐ All relevant information ☐ Only specific information (please specify): ________	

Name:	Role: ☐ GP ☐ Gynaecologist ☐ Psychologist ☐ Pain Specialist ☐ Physiotherapist ☐ Other (please specify): ________
Contact information:	
I consent for the following information to be shared: ☐ All relevant information ☐ Only specific information (please specify): ________	

Name:	Role: ☐ GP ☐ Gynaecologist ☐ Psychologist ☐ Pain Specialist ☐ Physiotherapist ☐ Other (please specify): ________
Contact information:	
I consent for the following information to be shared: ☐ All relevant information ☐ Only specific information (please specify): ________	

List any people that you <u>do not</u> provide consent to share information with:

Please note: Endometriosis Clinic has a duty of care to all its patients. In situations where there is a concern for a patient's welfare, these requests may not be able to be respected.

☐ I consent to being contacted for the purposes of endometriosis research studies.

Patient name:	Patient signature:	Date:
Staff name:	Designation:	
Signature:		Date:

06/23

JULIA ARGYROU ENDOMETRIOSIS CENTRE AT EPWORTH - INFORMATION DISCLOSURE CONSENT