Government of South Australia
SA Health

Pelvic Mesh Clinic
Patient Referral Form

This questionnaire is to be completed by a Doctor.
It is expected that the questionnaire will be completed in the presence of the patient, with their consent.

NB: All fields must be completed to enable processing of referrals.

PATIENT DETAILS	
Family name:	**Given name:**
DOB:	**Date of Referral:**
Address:	
Phone (M):	**Phone (H):**
Email:	
Cultural Status: ☐ Aboriginal ☐ Torres Strait Islander ☐ Both Aboriginal and Torres Strait Islander **Aboriginal Health Service and Contact:** ☐ Neither	Country of Birth: Language Spoken: Interpreter required: ☐ Yes ☐ No Cultural &/or Religious considerations: ☐ Yes ☐ No If yes:
Medicare No:	**Ref No:** **Medicare expiry date:**

REFERRER & GENERAL PRACTITIONER DETAILS		
Name:	**Provider number:**	
Organisation/practice name:	**Address:**	
Phone:	**Fax:**	**Signature:**
Is the referrer the patient's primary GP? ☐ Yes ☐ No, please complete primary GP details below		
GP Name:	**Organisation/practice name:**	
Address:	**Phone:**	
Is the GP aware of the patient being referred to the Pelvic Mesh Clinic? ☐ Yes ☐ No		

SUBJECTIVE ASSESSMENT

1. Patient-reported symptoms:

2. How long has the patient reported having symptoms? _____ weeks / months / years

3. How often does the patient experience their reported symptoms and pain?

☐ Daily ☐ 2-3x / week ☐ Weekly ☐ Fortnightly ☐ Monthly ☐ Seasonal (e.g. every few months)

4. What triggers has the patient identified which makes their symptoms worse?

☐ time of menstrual cycle	☐ intercourse	☐ lifting	☐ sitting down	☐ stress
☐ full meal	☐ full bowel	☐ bowel movement	☐ full bladder	☐ urination
☐ standing	☐ walking	☐ exercise	☐ time of day	☐ weather
☐ contact with clothing	☐ coughing/sneezing	☐ not related to anything	☐ other (please specify)	

_____

5. Does the patient complain of pain with sexual intercourse?

☐ Yes ☐ No ☐ Unable to have intercourse due to the pain ☐ Not applicable

6. Does the patient report that their sexual partner complains of pain, scratching or injury with intercourse?

☐ Yes ☐ No

MENTAL HEALTH & QUALITY OF LIFE IMPACT

1. On average, what is the patient's daily pain score?

Very low — *Average* — *Severe Pain*

0 1 2 3 4 5 6 7 8 9 10

2. How would the patient describe their mental health &/or mood recently?

Severely depressed — *Normal/Neutral* — *Feeling great*

0 1 2 3 4 5 6 7 8 9 10

3. Which of the following does the patient's symptoms &/or pain have a significant impact on?

☐ Mood ☐ Relationships ☐ Activities of Daily Living ☐ Mobility ☐ Sleep ☐ Work/Home Duties

4. As a direct result of their symptoms &/or pain:
a) has the patient decreased the number of contracted/paid hours of employment OR
b) have they been approved for a disability pension &/or in-home ADL assistance?

☐ Yes ☐ No **Details:**

INVESTIGATIONS *Please indicate below if the following have been completed, when and where:*			
Vaginal Swab: ☐ Yes ☐ No	**Date:**	**Where:**	**Result:**
Pelvic &/or Renal Ultrasound: ☐ Yes ☐ No	**Date:**	**Where:**	**Result:**
Urine Specimen: ☐ Yes ☐ No	**Date:**	**Where:**	**Result:**
PV Examination: ☐ Yes ☐ No	**Date:**	**Where:**	**Result:**
Other:			

GYNAECOLOGICAL SURGERY *HISTORY* *including details of mesh implants (if known)*

Please attach a copy of all RELEVANT CORRESPONDENCE from any clinician(s) / specialist(s) that have been involved in the management of this patient, INCLUDING OPERATION / DISCHARGE SUMMARIES.

MEDICATIONS *Please attach a medication summary*

1. **Is the patient currently prescribed, and using, any form of Oestrogen?** ☐ Yes, _____ ☐ No

ADDITIONAL INFORMATION

Please forward this form completed, along with copies of all requested documentation and reports to the:

Attn: Nurse Consultant
SA Health Pelvic Mesh Clinic - 3E106.01
Royal Adelaide Hospital
Adelaide SA 5000

Fax: 08 8124 1416 (Referral Hub)
Email: HealthRAHOPDreferrals@sa.gov.au **OR** Health.PelvicMeshSupportService@sa.gov.au
Phone: 1800 66 6374 (1800 66 MESH) **OR** 0466 927 997