MenopauseService

Illawarra Shoalhaven Local Health District

ISLHD Menopause Clinic Referral Form

Please email completed referral form to ISLHD-MenopauseService@health.nsw.gov.au
Menopause Service contact no. 0436 408 533

Patient Details: Date of referral: _____

Family name: Given name(s):

Date of Birth:

Medicare Number: Expiry Date:

Address: Postcode:

Phone number:

Does this patient identify as Aboriginal and / or Torres Strait Islander? No

Does this patient require an interpreter? No YES, language:

Patient history (tick all that apply):

- ☐ Women < 40 years old who have gone into menopause, including medical or surgical
- ☐ Breast/ovarian cancer diagnosis/ Genetic mutation- BRCA cancer risk or strong family history
- ☐ Premature Ovarian Insufficiency
- ☐ Migraine cyclical with aura
- ☐ Thromboembolic disease
- ☐ Cardiovascular disease
- ☐ Diagnosed osteoporosis requiring specialised endocrine consult or history of pathological fractures
- ☐ Severe ongoing symptoms despite trial first line MHT for 3 months
- ☐ Significant mood disorders associated with hormonal changes
- ☐ Complex social situations/priority population
- ☐ **At the patient's request**

Other relevant medical or surgical history: _____

Current medications: _____

PLEASE ATTACH ANY SUPPORTING DOCUMENTATION e.g. pathology/imaging/correspondence

Patient symptoms (tick all that apply):

- ☐ Vasomotor- hot flushes/night sweats/palpitations
- ☐ Genito-urinary symptoms
- ☐ Sleep disturbance
- ☐ Mood/mental health changes
- ☐ Joint pain/fatigue
- ☐ Cognitive changes (memory, brain fog)

Referrer's details

Name: Contact Number:

Position and location: