Gynaecology Referral Form
Wollongong Hospital

Health
Illawarra Shoalhaven
Local Health District

Fax referral to: 4222 5698
We request all referrals be addressed to a named medical practitioner.

Gynaecology Services

Dear □ Dr R.Chinoy □ Dr W.Davis □ S. Dikshit □ Dr H. Ananthram □ Dr B. Murali □ Dr L. Reyftmann □ Dr E. Tetstall

Patient Details

Last Name | Previous TWH / SDMH/ MUH patient ❒ Yes ❒ No

First Name

Date of Birth | Medicare Number | Exp. Date

Address | Health Insurance Fund

Suburb | Postcode | Health Insurance Number

Home Phone | Mobile | ATSI ❒ Yes ❒ No

Interpreter required? ❒ Yes ❒ No | Disability or special needs ❒ Yes ❒ No | Specify

Language | Country of birth

Referring Doctor

Print Name	Provider Number	
Practice Address	Suburb	Postcode
Phone	Fax	

Reason for Referral / Diagnosis *Please provide significant symptoms, signs, investigation results and any reasons that identify a need for early hospital assessment. If there is insufficient information, triaging will be delayed*

_____

_____

_____

Relevant co-morbidities / past medical / psychiatric / genetic / family history

_____

_____

Other Relevant Information

_____

_____

Medicines - _____

Allergies - _____

BMI: ❒ <35 ❒ > 35

Investigation Results *Please attach all relevant investigation results to assist us to triage correctly*

Pathology Provider _____ Radiology Provider _____

Tests attached

FBE	❑	Tumour markers	❑
Ferritin	❑	Hormonal studies	❑
TFTs	❑	Coagulation profile	❑
MSU	❑	Pap smear	❑
Swabs	❑	Pelvic ultrasound	❑
Mammogram	❑	Other:	❑

Doctor's Signature: _____ **Date:** _____

Referrals are triaged by a clinician based on the anticipated need for level of care and urgency of care

Appointment details will be sent to the referred patient.