Government of South Australia
SA Health

Pelvic Mesh Patient Referral Form

This questionnaire is to be completed by the Doctor. It is anticipated the questionnaire will be completed by the Dr in the presence of the patient who should provide the relevant information.

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

PATIENT DETAILS

Family name:		**Given names:**
DOB:		**Date of Referral:**
Address:		
Phone (H):	**Phone (W):**	**Phone (M):**

Aboriginal and or Torres Strait Islander Status:

- ☐ Aboriginal
- ☐ Torres Strait Islander
- ☐ Both Aboriginal and Torres Strait islander
- ☐ Neither

Aboriginal Health Service and Contact: _____

Culturally and Linguistically Diverse? Yes ☐ No ☐

Country of Birth: _____

Interpreter required? Yes ☐ No ☐

If Yes, what language?

_____

Medicare card no:	**Medicare expiry date:**

REFERRER'S DETAILS

Name:		**Provider number:**
Organisation/practice name:		**Address:**
Phone:	**Fax:**	**Signature:**

PATIENT ASSESSMENT QUESTIONNAIRE

1. **Patient symptoms** (i.e. pain, vaginal discharge, bowel/bladder concerns)

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

3. **What has the patient identified 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)	

PATIENT EXAMINATION FINDINGS

(i.e. vaginal, MC&S – urine, LVS, Ultrasound)

MENTAL HEALTH

4. How would the patient describe their mood most of the time for the last 3 months?

☐ Good ☐ Low/depressed ☐ Angry ☐ Anxious ☐ Other_____

GYNAECOLOGICAL SURGERY

5. Note any relevant gynaecological surgery, including details of mesh implants (if known).

6. Please attach a copy of the patient's MEDICAL RECORD from the unit where relevant surgery was undertaken, along with a copy of all RELEVANT CORRESPONDENCE from any clinician(s) / specialist(s) that have been involved in the management of this patient.

MEDICATIONS

7. Please attach the PATIENT MEDICATION print out.

DIAGNOSTICS

8. Please attach any relevant patient PATHOLOGY REPORT and MR / ULTRASOUND REPORT
(or cc the *Pelvic Mesh Clinic* in on the Ultrasound report)

SEXUAL INTERCOURSE

9. Does the patient complain of pain with sexual intercourse?		Yes		No
10. Does the patient report that their sexual partner complains of pain with intercourse		Yes		No

QUALITY OF LIFE

11. Has the patient had to reduce work hours/duties due to their pain/symptoms?		Yes		No

12. In an average month how many days has the patient reported pain? ___ / month

13. What is the patient's pain score on average?	0 *No pain*	1	2	3	4	5	6	7	8	9	10 *Severe Pain*

14. On a scale of 1–10, describe how the patient's pain has interfered in the following areas of their life: (*Circle as appropriate*)
For example, 0 = No interference and 10 = Completely interferes

• **general day-to-day activities**	0	1	2	3	4	5	6	7	8	9	10
• **patient's mood**	0	1	2	3	4	5	6	7	8	9	10
• **patient's ability to walk**	0	1	2	3	4	5	6	7	8	9	10
• **patient's relationship with other people**	0	1	2	3	4	5	6	7	8	9	10
• **patient's sleep**	0	1	2	3	4	5	6	7	8	9	10

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

Attn: Nurse Consultant
Pelvic Mesh Clinic 3E106.01
Royal Adelaide Hospital
Port Road ADELAIDE SA 5000

Fax: 08 8124 1416
Email: Health.PelvicMeshSupportService@sa.gov.au

For more information please contact:
RAH Pelvic Mesh Clinic on 0466 927 997 or Helpline 1800 66 6374 (1800 66 MESH)