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| Queensland Pelvic Mesh Service    General Practitioner Referral | | | | | | | | |
| **Attention** | Queensland Pelvic Mesh Service  **Dr Malcolm Frazer**  Varsity Lakes Day Hospital, 2 Lake Street, Varsity Lakes QLD 4227  Phone: 07 5619 0772 Fax: 07 5619 0677 | | | | | | | |
| **Date of referral** |  | | | | | | | |
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| **Patient Information** | | | | | | | | |
| Family name: | | | | | Given name(s): | | | |
| Date of birth: | | | | | Medicare number: | | | |
| Address: | | | | | | | | Postcode: |
| Phone number: | | | | | Alternative phone number: | | | |
| Next-of-kin / alternative contact name: | | | | | | | Phone number: | |
| Does this patient identify as Aboriginal and / or Torres Strait Islander:  Yes  No  Unknown | | | | | | | | |
| Does this patient require an interpreter:  Yes  No If *Yes*, language: | | | | | | | | |
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| **Referring General Practitioner Information** | | | | | | | | |
| Dr: | | | | | | | | |
| Practice: | | | | | | | | |
| Address: | | | | | | | | Postcode: |
| Phone number: | | | | Fax number: | | Provider number: | | |
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| **Queensland Pelvic Mesh Service Inclusion Criteria (mandatory)** | | | | | | | | |
| 1. The patient has had vaginally or abdominally placed mesh products for treatment of vaginal prolapse and / or urinary incontinence; *AND* | | | | | | | | Yes  No |
| 1. Is a current resident in the state of Queensland or had their initial mesh surgery performed in the state of Queensland (referrals from the usual Gold Coast Hospital and Health Service catchment area will also be accepted); *AND* | | | | | | | | Yes  No |
| 1. The patient’s quality of life is adversely affected by the mesh and mesh-related issues; *AND* | | | | | | | | Yes  No |
| 1. The patient is willing to participate in further assessment within a multidisciplinary service. | | | | | | | | Yes  No |
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| **Relevant Patient History** | | | | | | | | |
| Reason for referral: | | | | | | | | |
| Patient goals of care: | | | | | | | | |
| Provisional diagnosis (if available): | | | | | | | | |
| Date and location of pelvic mesh surgery(s) (if known): | | | | | | | | |
| Pelvic mesh product(s) (if known): | | | | | | | | |
| Patient symptoms, onset and treatment to date: | | | | | | | | |
| Provide any other relevant history, clinical examination findings and treatment to date (if required): | | | | | | | | |
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| **Physical Health Assessment Findings (inclusive of)** | | | | | | | | |
| BMI: | | Dyspareunia:  Yes  No Unprovoked pain at rest:  Yes  No  Abnormal PV bleeding:  Yes  No | | | | | | |
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| **Investigations** | | | | | | | | |
| **Minimum mandatory investigations attached** | | | FBC:  Yes  Patient declined U&Es:  Yes  Patient declined  LFT:  Yes  Patient declined Urine MCS:  Yes  Patient declined | | | | | |
| **Recommended investigations to  include** (if available) | | | Imaging studies: | | | | | |
| ***Please attach any relevant previous medical notes or correspondence.*** | | | | | | | | |
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| **Social Factors and Impact on the Patient** | | | | | | | | |
| Employed  Self-employed  Student  Please specify: | | | | | | | | |
| Dependents: | | | | | | | | |
| ***Please notify of previous or current substance abuse, self-harm or significant mental health symptoms or disorder.*** | | | | | | | | |
| Consider the impact on employment / education; activities of daily life; ability to care for others; personal safety / frailty; other factors –  provide relevant information: | | | | | | | | |
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| **Mental Health History** | | | | | | | | |
| Does the patient have a current mental health plan:  Yes  No  If *Yes*, the plan has been attached with the patient’s consent:  Yes  No | | | | | | | | |
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| **Relevant Medical History (including co-morbidities and previous surgical interventions)** | | | | | | | | |
| ***Please attach a summary of the patient’s medical records which includes medications, allergies and important medical history.*** | | | | | | | | |
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| Smoking status:  Current smoker  Previous smoker  Never smoked | | | | | | | | |
| Allergies: | | | | | | | | |
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| **Please fax completed referral form to 07 5619 0677**  **For any queries relating to this referral template please contact the Queensland Pelvic Mesh Service**  **on 07 5619 0772 or** [**QPMSReferralsGCHHS@health.qld.gov.au**](mailto:QPMSReferralsGCHHS@health.qld.gov.au) | | | | | | | | |

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