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.

<table>
<thead>
<tr>
<th>PATIENT DETAILS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Family name:</strong></td>
</tr>
<tr>
<td><strong>DOB:</strong></td>
</tr>
<tr>
<td><strong>Address:</strong></td>
</tr>
<tr>
<td><strong>Phone (H):</strong></td>
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</tbody>
</table>

**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:** |

<table>
<thead>
<tr>
<th>REFERRER’S DETAILS</th>
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<tbody>
<tr>
<td><strong>Name:</strong></td>
</tr>
<tr>
<td><strong>Organisation/practice name:</strong></td>
</tr>
<tr>
<td><strong>Phone:</strong></td>
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<table>
<thead>
<tr>
<th>PATIENT ASSESSMENT QUESTIONNAIRE</th>
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<tbody>
<tr>
<td><strong>1.</strong> Patient symptoms (i.e. pain, vaginal discharge, bowel/bladder concerns)</td>
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</tbody>
</table>

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

<table>
<thead>
<tr>
<th>PATIENT EXAMINATION FINDINGS</th>
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<tbody>
<tr>
<td>(i.e. vaginal, MC&amp;S – urine, LVS, Ultrasound)</td>
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</table>
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?  
   
<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>No pain</td>
<td>Severe Pain</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>
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

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

Attn: Jess Webb, Joya McCormack
Triage Nurse
Pelvic Mesh Clinic
Royal Adelaide Hospital

Fax: 08 707 46247
Email: Health.PelvicMeshSupportService@sa.gov.au