# NATIONAL OVARIAN CANCER GP REFERRAL FOR SYMPTOMATIC WOMEN

National Cancer Control Programme

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

**This referral form should ONLY be used where ovarian cancer is suspected. Other gynaecological conditions that require specialist consultation can be referred in the usual manner to any general gynaecology clinic.**

**Please follow the referral guideline and insert the required clinical information on this form to refer a patient to: A) ANY radiology department for an ultrasound or B) directly to ONE gynae-oncology centre.**

**For direct gynae-oncology referrals please POST or FAX this FORM to ONLY ONE of the Hospitals listed below to avoid duplication**

| | | | | | |
|---|---|---|---|---|---|
| ☐ Cork University Maternity Hospital | Tel: 021 4920711 | Fax: 021 4920677 | ☐ St James's Hospital Dublin 8 | Tel: 01 4162239 | Fax: 01 4103364 |
| ☐ Galway University Hospital | Tel: 091 544529 | Fax: 091 542044 | ☐ Mater University Hospital | Tel: 01 803 4448 | Fax: 01 805 6282 |
| ☐ University Hospital Limerick | Tel: 061 482311 | Fax: 061 485305 | ☐ University Hospital Waterford | Tel: 051 842778 | Fax: 051 842132 |
| ☐ St Vincent's University Hospital | Tel: 01 2216594 [Mon/Tues/Wed] | Tel: 01 2213055 [Thurs/Fri] | Fax: 01 221 4318 | | |

## PATIENT DETAILS

Surname: _____

First Name: _____ DOB: _____

Address: _____

_____

Mobile No: _____ Tel day: _____

Tel evening: _____

Hospital No. (if known): _____

First language: _____ Interpreter needed: ☐ Yes

Wheelchair assistance: ☐ Yes

## GENERAL PRACTITIONER DETAILS

Name: _____

Address: _____

_____

_____

Telephone: _____ Mobile: _____

Fax: _____

GP Signature: _____ Date of referral: _____

Medical Council Registration No.: _____

## REFERRAL INFORMATION

**Is this referral for pelvic ultrasound?** ☐ **Yes** ☐ **No**

If yes what is the CA125 result: _____ kU/L

In what hospital was the CA125 test analysed _____

Date of CA125 test(s) _____

**Is this a referral to gynae-oncology?** ☐ **Yes** ☐ **No**

If yes does the patient have:

| | | |
|---|---|---|
| • Unexplained ascites / pelvic mass | ☐ Yes | ☐ No |
| • US suggestive of ovarian cancer (attach report) | ☐ Yes | ☐ No |
| • CA125>200kU/L | ☐ Yes | ☐ No |
| • Elevated CA125 (>35kU/L) that on repeat testing after 6 weeks continues to rise (attach report(s)) | ☐ Yes | ☐ No |

## PAST MEDICAL / FAMILY HISTORY

**Please tick as appropriate**

**Family history:**

☐ Ovarian cancer

☐ Breast cancer

**Menopausal status:**

☐ Post-menopausal (>1yr since LMP)

☐ Hysterectomy

☐ On HRT, for _____ years

Previously seen by Gynaecologist? ☐ Yes ☐ No

Consultant name: _____

Location: _____

Year: _____

Diagnosis if known: _____

_____

Allergies? ☐ Yes ☐ No

Anticoagulants? ☐ Yes ☐ No

Medication? ☐ Yes ☐ No

List Medication: _____

_____

_____

_____

## FOR HOSPITAL USE:

Date of referral received: _____

Date of appointment offered: _____

Reason patient did not accept first appointment offered: _____

**Gynae-oncology Triage Team**

☐ Urgent Referral *for gynae-oncology*

☐ Routine Referral *(diverted to routine gynaecology clinic)*

Triaged by: _____

*This form will be reviewed as new evidence emerges.*