Western Health

Transvaginal Mesh Management Service

Referral Form

Phone: 0481 908 118
Fax referral to 8345 1691

Date of referral:.....

Hospital UR#:.....
Name: .....
Address: .....
Suburb: .....
Postcode: ..... **Telephone:** .....
DOB:_____/_____/_____**Marital Status:** .....
Medicare No: ..... **IRN:** ..... **Exp date:** .....
Interpreter Req: ☐ **No** ☐ **Yes: Language** .....

Reason for referral: Previous transvaginal mesh procedure and
☐ Irregular vaginal bleeding or discharge - Details: .....
☐ Pain – Location, duration and nature – Details: .....
☐ Discomfort during intercourse - Details: .....
☐ New or recurrent prolapse, bladder or bowel symptoms - Details: .....
☐ Recurrent urinary tract or vaginal infections - Details: .....
☐ Palpable or exposed mesh – Details: .....
☐ Vaginal adhesions or scarring – Details: .....
☐ Asymptomatic but patient concerns – Details: .....
☐ Other – Details: .....

Examination findings: (NAD = No Abnormalities Detected)
Abdomen: ☐ NAD ☐ Abnormal findings: .....
Digital exam: ☐ NAD ☐ Abnormal findings: .....
Speculum: ☐ NAD ☐ Abnormal findings: .....
Other – Details: .....

Investigations - Abnormal findings: ☐ No ☐ Yes Investigations attached: ☐ Yes ☐ No
Details: .....
.....

Mesh Procedure details:
Indications for procedures: ☐ Urinary Incontinence ☐ Pelvic Organ Prolapse ☐ Bowel symptoms
Number of mesh procedures performed: ……
If known:
Date/s of procedure/s: .....
Hospital/s: .....
Surgeon/s: .....
Name of Mesh product/s: .....
Operation Notes attached: ☐ Yes ☐ No
Previous attempt at mesh removal or other treatment: ☐ Yes ☐ No
Details: .....

Relevant Medical/Surgical History:
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Referrer details: (☐ GP ☐ Gynaecologist ☐ Other:.....) Primary GP aware of Referral: ☐ Yes ☐ No
Name: ..... Tel: .....
Clinic Name: ..... Fax: .....
Address: .....Mob: .....
Provider No:.....