CLARITY
MENOPAUSE CLINIC

Referral Form

CLARITY MENOPAUSE CLINIC
Mullingar Healthcare Complex
Austin Friar St. Mullingar, Co. Westmeath
N91 ED2H

This form is for patients wishing to self-refer, for a GP/clinical staff member referring on behalf of a patient. Please complete all the relevant sections. A member of our clinical team will review your referral and contact you within 5 working days.

URGENT: If you are experiencing severe pain, heavy uncontrolled bleeding, or any emergency symptoms, please contact your GP or attend your nearest A&E immediately. Do not use this form in an emergency.

1 – REFERRAL TYPE

Please tick one:
☐ Self-referral (completed by the patient)
☐ GP / Clinical staff referring on behalf of a patient

GP REFERRAL – PATIENT'S GP DETAILS

_____ _____
GP Name *GP Practice Name*

_____ _____
GP Practice Address (street, town, county, eircode) *GP Healthmail address (format: name@healthmail.ie)*

REFERRING CLINICIAN DETAILS

_____ _____
Referring Clinician Name *Role / Title*

_____ _____
Contact Number *Clinician Email Address*

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2 – PATIENT DETAILS

_____ _____
Full Name *Date of Birth* (DD MM YYYY)

_____
Street Address

_____ _____ _____
(Town/City) *(County)* *(Eir Code)*

_____ _____ _____
Email address *Cell Number* *Work Number*

Which is your preferred method of contact?
☐ Cell ☐ Work

May we leave messages on your preferred number?
☐ Yes, any message ☐ Only appointment information ☐ No message

_____
(Registered GP Practice)

3 – REASON FOR REFERRAL

Please select all areas that apply:
☐ Menopause
☐ Pre-menopause / perimenopause symptoms
☐ Post-menopause concerns
☐ Hormone Replacement Therapy (HRT) – new, review or change
☐ Pre-pregnancy planning / optimisation
☐ Early pregnancy concern or support
☐ Fertility concerns or investigation
☐ Gynaecological screening (smear, colposcopy, ultrasound)
☐ Contraceptive advice, fitting or removal
☐ Other gynaecological concern

_____

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info@claritymenopause.ie

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4 – SYMPTOM DETAIL

Please describe your main symptoms or concerns

_____

How long have you had these symptoms? *

_____

5 – MENSTRUAL & REPRODUCTIVE HISTORY

_____ _____

Date of Last Menstrual Period (LMP) *Are You Currently Pregnant?*

_____ _____

Number of Previous Pregnancies *Number of Live Births*

_____ _____

Current Contraception (if any) *Date of Last Cervical Smear*

Any previous gynaecological surgeries or procedures? (include approximate dates if known)

_____

6 – MEDICAL HISTORY

Relevant medical conditions

_____

Current medications (including supplements and over-the-counter)

_____

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Known allergies or adverse reactions

_____

Family history relevant to this referral

_____

Please indicate if any of the following apply:

- ☐ Personal or family history of breast cancer
- ☐ Personal or family history of blood clots (DVT / PE)
- ☐ History of endometriosis or PCOS
- ☐ History of fibroids
- ☐ Liver disease
- ☐ Current smoker

6 – LIFESTYLE (OPTIONAL)

_____ *BMI or weight (if known)*

_____ *Alcohol units per week*

_____ *Are you a current smoker?*

7 – ADDITIONAL INFORMATION

Is there anything else you would like the clinical team to know before your appointment?

_____

7 – CONSENT & DECLARATION

Your personal and health information will be held securely and used only for the purposes of your clinical care at Clarity Menopause Clinic. Information may be shared with your registered GP and relevant health services as part of your care pathway. We will not share your information with third parties without your consent, except where required by law. You have the right to access your data at any time. Please see our privacy Notice for full details.

- ☐ I confirm that the information is accurate and complete to the best of my knowledge *
- ☐ I consent to my information being used for the purposes of my clinical care as described above *
- ☐ I confirm that this form does not guarantee an appointment and that a clinical trial will take place before my referral is confirmed.

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FOR PATIENT

Signature or full name (if completing digitally) Date

_____ _____

FOR GP / CLINICAL STAFF

Relationship to Patient Date

_____ _____

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