## Patient Referral Checklist for Pelvic Pain



MEDICAL HISTORY					
Initials:	Onset of Pelvic Pain (years):		Medical Allergies:	Reproductive History: G P A L	
Age:	Triggers of Pelvic Pain:			Family History of Endometriosis: 🔾 Yes 🔾 No	
				Other:	
Comorbidities:		Significant Past Medical History:		unci.	

PHYSICAL EXAM & L	ABS	DATE	FINDINGS (if exam/labs done)
Pelvic exam (if sexually active)			
Pap smear (if sexually active)	O Yes O No		
Vaginal/cervical swabs	O Yes O No		
Urinalysis +/- cultures	O Yes O No		
Other	O Yes O No		

	DIAGNOSTIC IMAGING (Please append relevant results.)			
	Transabdominal ultrasound*			
	Transvaginal ultrasound*			
	Other (e.g., MRI, CT scan)			
	Specify:			
_	*To be done prior to referral.			

<b>PREVIOUS CONSULTATION REPORTS</b> (Please append relevant consult letters.)		
	Gynaecologist	
	Other (e.g., urologist, psychiatrist, neurologist, endocrinologist, Gl specialist, surgeon) Specify:	

<b>PREVIOUS TREATMENTS</b> (Please complete the table below and append any relevant findings/results.)			
Previous Treatment	Response	Duration of Trial	Notes
NSAIDs	O Yes O No		
Cyclic combined oral contraceptives	• Yes • No		
Continuous combined OCs	• Yes • No		
LNG-IUS	• Yes • No		
Progestin - oral	O Yes O No		
Progestin - IM	O Yes O No		
GnRH with combined HT add-back	• Yes • No		
Danazol	O Yes O No		
Levonorgestrel	O Yes O No		

PREVIOUS ABDOMINAL/PELVIC LAPAROSCOPY AND/OR SURGERY (Please append surgical notes or reports.)				
Type of Procedure	Date of Procedure	Notes or Reports		