## 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<br>O No |      |                              |
| Vaginal/cervical swabs           | O Yes<br>O No |      |                              |
| Urinalysis +/- cultures          | O Yes<br>O No |      |                              |
| Other                            | O Yes<br>O No |      |                              |

|   | DIAGNOSTIC IMAGING<br>(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><br>(Please append relevant consult letters.) |  |  |
|---|--|--|
|   | Gynaecologist  |  |
|   | Other (e.g., urologist, psychiatrist, neurologist, endocrinologist,<br>Gl specialist, surgeon)<br>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 |  |  |
|   |                   |                  |  |  |
|   |                   |                  |  |  |
|   |                   |                  |  |  |