PELVIC MASS CLINIC REFERRAL FORM

Name: **D.O.B:** **Hospital No.** **Address:**	**Referring Clinician:** **Job Title:** **Email:** **Named consultant:** **Referred from: GOPD/ EGU / EPAU / ANC / Other** **Date of Referral:**

Symptoms		Duration
Scan findings		Date
CA 125		Date

Reason for referral to the Pelvic Mass Clinic (please insert X)

Second opinion scan		**To take over care of patient**	
Other – please provide details			

Reason for Urgency of the referral to the Pelvic Mass Clinic (please insert X)

Symptoms		**Complex cyst**		**Raised CA 125**		**Age**	
Other – please provide details							

Please email your completed form to gynaecology.oncology.cav@wales.nhs.uk