Queensland Government

Royal Brisbane & Women's Hospital

QUEENSLAND TROPHOBLAST CENTRE REFERRAL

TO: DR DAVID BAARTZ / DR ANDREA GARRETT
WOMEN'S & NEWBORN SERVICES, RBWH

(Affix patient identification label here or write details below)

RBWH URN *(if applicable)*: .....

Family name: .....

Given names: .....

Date of birth: ..... Sex: ☐ M ☐ F ☐ I

Address: .....

.....

Phone - Home: ..... Work: .....

Mobile: .....

Email address: .....

Medicare No: ..... Ref No: .....

Next of kin details:
Surname: .....

Given names: .....

Phone No: ..... Relationship: .....

Referring Consultant Details

Provider No: .....

Name: .....

Address: .....

.....

Phone: ..... Fax: .....

GP Details

Name: .....

Address: .....

.....

Phone: ..... Fax: .....

Please confirm that the need for follow up has been discussed with the patient, the procedure has been explained to her and that she is aware the QTC will contact her: ☐ Yes

Ethnic Origin: ☐ Caucasian ☐ Aboriginal or TSI ☐ Asian ☐ South American ☐ Other *(specify)*: .....

Is an Interpreter required: ☐ Yes ☐ No If *Yes*, specify language: .....

Obstetric History

Number of pregnancies (including this one): ..... Number of live births: .....

Number of miscarriages / terminations / ectopic pregnancies (including this one): .....

Was there a pregnancy associated with this registration? ☐ Yes ☐ No

If *Yes*, what was the outcome? ☐ Live birth ☐ Abortion ☐ Miscarriage ☐ Ectopic ☐ Still birth ☐ Mole

What was the date of delivery or termination of the associated pregnancy? ...../...../.....

Was there a pregnancy prior to this registration? ☐ Yes ☐ No

If *Yes*, what was the outcome? ☐ Live birth ☐ Abortion ☐ Miscarriage ☐ Ectopic ☐ Still birth ☐ Mole

Date of delivery or termination of pregnancy prior to registation: ...../...../.....

Has the patient had a previous hydatidiform mole? ☐ Yes ☐ No If *Yes*, date diagnosed: ...../...../.....

Is there a family history of hydatidiform mole? ☐ Yes ☐ No ☐ Unknown

Clinical Information

Events leading to diagnosis *(Please tick all that apply)*:

☐ Vaginal bleeding ☐ Hyperemesis ☐ Hyperthyroidism ☐ Ovarian cysts

☐ Passage of molar tissue ☐ Preeclampsia ☐ Anaemia ☐ Recurrent bleeding post abortion

☐ Pain ☐ Findings on Imaging Bhcg at time of diagnosis: ..... Date of Bhcg at diagnosis: ...../...../.....

Gestational age: ...../40 weeks Uterine size: ...../40 weeks

Date of last menstrual period prior to evac: ...../...../..... Size of tissue *(if known)*: .....

How was the Hydatidiform Mole diagnosed? ☐ Ectopic pregnancy (salpingectomy) ☐ Evacuation of uterus

Diagnostic Information

Method of evacuation: ☐ Spontaneous ☐ Sharp curettage ☐ Suction curettage ☐ Combined suction / sharp

Date of evacuation: ...../...../

Was Syntocinon used? ☐ Yes ☐ No

Was Misoprostol used for cervix ripening? ☐ Yes ☐ No

Were there any complications of the evacuation? ☐ Yes ☐ No If *Yes*, please state: .....

Classification of mole: ☐ Possible molar pregnancy ☐ Partial ☐ Complete ☐ PSTT ☐ Choriocarcinoma ☐ ETT

Site of mole: ☐ Uterine ☐ Ectopic

Was cytogenics performed? .. ☐ Yes ☐ No If *Yes*, please state: .....

Pathologist: ☐ QHPSS ☐ Mater Pathology ☐ QML ☐ S&N ☐ Other *(specify)*: .....

Twin pregnancy ☐ Yes ☐ No ☐ Unknown

IMPORTANT: PLEASE ATTACH A COPY OF THE HISTOLOGY, IMAGING (ANTENATAL USS) AND OTHER RELEVANT INVESTIGATIONS

Signed: ..... Print Name: ..... Designation: ..... Date: ...../...../.....

Please fax completed form to 1300 364 952 Attn: CPIU

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