**Unscheduled Bleeding on HRT Urgent Trans-vaginal Ultrasound Scan Request Form**

**(***For patients on HRT with unscheduled bleeding only***)**

Please complete ALL fields below, incomplete forms may delay assessment.

**If 1 major or 3 minor risk factors for endometrial cancer, please use USCP referral.**

Please see the local guidelines on the Devon Formulary website if you are unsure whether your patient requires referral.

|  |  |  |  |
| --- | --- | --- | --- |
| **\*Referrer Details:** (reports should be sent to the referrer) | | | |
| **Referrer Name:** |  | **Registered GP:** |  |
| **Organisation :** |  | **Practice Code:** |  |
| **Tel No:** |  | **Fax No:** |  |
| **NHS Email Address (generic practice):** |  | **Date Referred:** |  |
| **Professional registration code (GMC code):** |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **\*Patient Details:** | | | |
| **UBRN:** |  | **NHS Number:** |  |
| **Surname:** |  | **Date of Birth:** | **Age:** |
| **Forenames:** |  | **Title:** |  |
| **Address (full):** | | | |
| **Postcode:** |  | **Mobile No:** |  |
|  |  | **Home Tel No:** |  |
| **Ethnic Origin:** |  | **Work Tel No:** |  |

|  |  |
| --- | --- |
| **Special Requirements** (including mobility, language support, hoist)**:** | |
|  | |
| **If an interpreter is required what language?** |  |

|  |  |
| --- | --- |
| **Indication for Unscheduled Bleeding on HRT Urgent TV Ultrasound -** Please inform patient that if scan is abnormal will be seen in USC pathway and if normal, they will receive a written report. | |
| **Unscheduled bleeding on HRT and any one of:** |  |
| First bleed more than 6 months after starting HRT | ☐ Yes |
| Bleeding continuing more than 3 months after adjustments of HRT in absence of other risk factors | ☐ Yes |
| On HRT and bleeding is prolonged or heavy | ☐ Yes |
| **OR** |  |
| **Unscheduled bleeding on HRT and any two of:** |  |
| BMI 30-39 | ☐ Yes |
| Diabetes | ☐ Yes |
| PCOS (or anovulatory cycles) | ☐ Yes |
| Unopposed oestrogen 3-6 months | ☐ Yes |
| Inadequate progestogen 6-12 months | ☐ Yes |
| Expired LNG-IUS | ☐ Yes |

|  |  |
| --- | --- |
| **Essential Information -** please complete ALL fields below, incomplete forms may delay assessment. | |
| Does the patient have a uterus and cervix? | ☐ Yes ☐ No |
| Has the patient undergone a sub-total hysterectomy? | ☐ Yes ☐ No |
| Are they on HRT | ☐ Yes ☐ No |
| If yes what type |  |
| Duration since last modification of HRT therapy |  |
| Do they have an LNG-IUS or Cu-IUD in place | ☐ Yes ☐ No |
| If on sequential HRT when was their last menstrual period |  |

|  |
| --- |
| **\*Relevant Clinical Indications** (key symptoms and signs. If possible please include details of any previous images or scans) |
|  |

|  |
| --- |
| **A recent Full Blood Count (FBC) – if available** |
|  |