BC WOMEN'S HOSPITAL+ HEALTH CENTRE
Provincial Health Services Authority

Endo Surgery Access Project Referral Form

BC Women's Centre for Pelvic Pain & Endometriosis
BC Women's Hospital + Health Centre
F2-4500 Oak St., Vancouver, BC V6H-3N1
T 604.875.2534 / F 604.875.2569
www.bcwomens.ca

Date: _____

Patient Name: _____ **Pronouns:** _____

Address: _____ **Best Phone Number:** _____

Date of Birth: _____ (DD/MM/YYYY) **PHN:** _____

****Email (Required)****: _____ ☐ Consent to contact by email

Fluent English ☐ Y ☐ N Interpreter Required ☐ Y ☐ N Language _____ Identify as Indigenous ☐ Y ☐ N

Referring Gynecologist
Name: _____
Phone: _____ Fax: _____
MSP#: _____

Primary Care Provider *(if different from referring)*
Name: _____
Phone: _____ Fax: _____
MSP#: _____

Please note that patients are not eligible for this program if:
- *They have significant sensitization (CSI >40)*
- *Have had previous failed surgery for endometriosis*
- *Have complete cul de sac obliteration by ultrasound or MRI*

If ineligible for the Endo Surgery Access Project, please send Clinic Referral Form instead

PLEASE SELECT REASON FOR REFERRAL:

☐ **Endometriosis Stage 1 – 2** (suspected superficial endometriosis & wanting surgery)

Methods tried/reason for referral

☐ Failed medical therapy ☐ Side effects ☐ Desiring pregnancy

CSI Score: _____ Pelvic Floor Finding: ☐ Non-tender ☐ Tender *(pls refer to community physio)*

Endovaginal sliding sign ultrasound ☐ Normal (positive) ☐ Abnormal (negative)

☐ **Ovarian Endometrioma** (unilateral or bilateral endometrioma & wanting surgery due to pain)

Methods tried/reason for referral

☐ Failed medical therapy ☐ Side effects ☐ Desiring pregnancy

AMH level: _____ *(Required if bilateral and/or desiring pregnancy)*

Other relevant information _____

_____

Please send copies of the following if available:

Done	Not Done	
☐	☐	Consultation
☐	☐	Endovaginal sliding sign ultrasound
☐	☐	MRI report

****Patients will not be triaged until <u>all</u> information regarding previous investigations is received****

Central Sensitization Interview: Part A

Name: _____ Date: _____

	Please write the number that applies to the right of each statement.	0	1	2	3	4	Score
1	I feel tired and unrefreshed when I wake from sleeping.	Never	Rarely	Sometimes	Often	Always	
2	My muscles feel stiff and achy.	Never	Rarely	Sometimes	Often	Always	
3	I have anxiety attacks.	Never	Rarely	Sometimes	Often	Always	
4	I grind or clench my teeth.	Never	Rarely	Sometimes	Often	Always	
5	I have problems with diarrhea and/or constipation.	Never	Rarely	Sometimes	Often	Always	
6	I need help in performing my daily activities.	Never	Rarely	Sometimes	Often	Always	
7	I am sensitive to bright lights.	Never	Rarely	Sometimes	Often	Always	
8	I get tired very easily when I am physically active.	Never	Rarely	Sometimes	Often	Always	
9	I feel pain all over my body.	Never	Rarely	Sometimes	Often	Always	
10	I have headaches.	Never	Rarely	Sometimes	Often	Always	
11	I feel discomfort in my bladder and/or burning when I urinate.	Never	Rarely	Sometimes	Often	Always	
12	I do not sleep well.	Never	Rarely	Sometimes	Often	Always	
13	I have difficulty concentrating.	Never	Rarely	Sometimes	Often	Always	
14	I have skin problems such as dryness, itchiness, or rashes.	Never	Rarely	Sometimes	Often	Always	
15	Stress makes my physical symptoms get worse.	Never	Rarely	Sometimes	Often	Always	
16	I feel sad or depressed.	Never	Rarely	Sometimes	Often	Always	
17	I have low energy.	Never	Rarely	Sometimes	Often	Always	
18	I have muscle tension in my neck and shoulders.	Never	Rarely	Sometimes	Often	Always	
19	I have pain in my jaw.	Never	Rarely	Sometimes	Often	Always	
20	Certain smells, such as perfumes, make me feel dizzy and nauseated.	Never	Rarely	Sometimes	Often	Always	
21	I have to urinate frequently.	Never	Rarely	Sometimes	Often	Always	
22	My legs feel uncomfortable and restless when I am trying to go to sleep at night.	Never	Rarely	Sometimes	Often	Always	
23	I have difficulty remembering things.	Never	Rarely	Sometimes	Often	Always	
24	I suffered trauma as a child.	Never	Rarely	Sometimes	Often	Always	
25	I have pain in my pelvic area.	Never	Rarely	Sometimes	Often	Always	
					Total=		