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

Surgical Mentorship 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 Surgical Mentorship Program, 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****