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| **General Gynaecology****MDM Referral Form** |



National Women’s Health

Private Bag 92 189

Victoria Street West

Auckland 1142

New Zealand

**DATE:**

**NHI:**

**PATIENT NAME: AGE:**

**REFERRING SPECIALIST**

• Consultant name:

• Email address:

**CLINICAL HISTORY:**

• Age:

• Brief clinical history:

• Co-morbidities:

• BMI:

• Ethnicity:

**KEY CLINICAL ASSESSMENT:**

**RADIOLOGY:**

• Type:

• Date:

• Location:

• Key findings:

**OPERATION:**

• Date:

• Surgeon:

• Findings:

**QUESTION FOR THE MDM?**

**ATTENDEES AT MDM:**

**OUTCOME FROM MDM:**