IUD Referral for GPs

Sexual Health Quarters

Date _____

Client Details

First name, Family name _____ Date of Birth _____

Address _____

_____ Phone number _____

History

Reason for considering IUD _____

Any abnormal menstrual symptoms? (intermenstrual bleeding, postcoital bleeding, breakthrough bleeding) Yes ☐ No ☐

If yes, investigate and DON'T refer to SHQ. Follow guidelines: Abnormal Vaginal Bleeding In Pre- And Peri-Menopausal Women, found at: https://tinyurl.com/3txn3uxs
SHQ will not insert IUDs for abnormal bleeding unless it has been fully investigated by a gynaecologist and we have evidence of the letter and the results from this investigation.

Any abnormal vaginal discharge or dyspareunia? Yes ☐ No ☐

If yes: Do not refer, please investigate.

_____

Usual cycle _____

LMP _____

Any other contraindications? (including abnormal cavity, breast cancer, current PID)

_____

Current contraceptive method _____

Any previous IUD use? _____

Obstetric history Gravity _____ Parity _____

Date of most recent delivery _____ Mode of all deliveries _____

Currently breastfeeding? Yes ☐ No ☐

Date and results of most recent CST _____

_____

_____

Does the client have any medical problems? _____

Is the client on any medications? _____

Any operations on the uterus? _____

Discussion

Other contraceptive options discussed Yes ☐ No ☐
Comment: _____

Choice of progestogen and copper devices discussed Yes ☐ No ☐

Efficacy discussed (>99%) Yes ☐ No ☐

Procedure explained Yes ☐ No ☐

Possible benefits, risks and adverse effects discussed, including non-insertion (3%), changes to bleeding, perforation (<1/1000), infection (1/300), expulsion (1-2/100), feeling faint, (5/100) hormonal side-effects Yes ☐ No ☐

Costs discussed. Please visit shq.org.au/clinic/visiting-our-clinic/clinic-costs Yes ☐ No ☐

Patient has been given information sheet and consent form to sign. Please visit: shq.org.au/clinic/information-for-professionals/iud-information-for-gps Yes ☐ No ☐

Pre-insertion analgesia discussed. Advise NSAID or paracetamol ½ hour to 1 hour prior to appointment Yes ☐ No ☐

Please instruct the client to eat prior to the appointment, and to arrange transport home after appointment (such as a family member or friend to assist them).

Examination Findings (if done)

Not Applicable ☐

Uterus non-tender Size, shape & position _____

Cervix non-tender _____

Adnexae non-tender, no masses _____

Investigations

SHQ will not process any IUD referrals until the following investigation results have been received:

☐ Screening for Chlamydia/Gonorrhea: CT/NG PCR (ECS, or SOLVS)

☐ Previous CST results ☐ N/A (if client under 25yo)

☐ Any previous non-obstetric pelvic ultrasound reports attached (if applicable)

☐ Other investigations done e.g, blood tests if required

☐ Copy of results sent to SHQ along with this referral letter (helpline@shq.org.au)

Plan

Pre-insertion contraception: it is vital there is no risk of pregnancy when the client presents. Please tick the method to be used:

- ☐ **Unexpired IUD: Advise abstinence for a week prior to exchange.**
- ☐ **Abstinence from LMP, or 3 weeks prior to insertion**
- ☐ **Contraceptive Implant**
- ☐ **Combined Oral Contraceptive Pill**
- ☐ **Progestogen Only Pill**
- ☐ **Contraceptive Injection**
- ☐ **Vaginal Ring**

Client preference: Progestogen IUD (☐ Kyleena or ☐ Mirena) Copper IUD ☐ Undecided ☐

Please prescribe the Mirena or Kyleena if this is preferred.
SHQ can provide Copper IUDs, refer to shq.org.au/clinic-costs for device costs.

Doctor has covered all the above information with me (Client) ☐

Client name _____ **Signature** _____ **Date** _____

Contact

Please fax/email this referral and all results to SHQ on 9228 9010 | helpline@shq.org.au

Please ask the client to contact the Sexual Health Helpline (SHH) to make an IUD appointment on 9227 6178 once all the results and the referral have been sent.

If the client requires a copper IUD for emergency contraception within 5 days of unprotected sexual intercourse, please contact SHH for an urgent appointment on 9227 6178 and we will attempt to assist.

Doctors Contact

Please sign and provide your contact details to confirm all the information on this form has been discussed with the client. Alternatively, use a Drs stamp below.

Doctors name _____
Doctors signature _____
Address _____
_____
Phone _____
Email _____
Provider number _____

Drs stamp