Institute of Gynaecology and Women's Health

Mr. Tom Walsh
Suite 12,
69 Eccles Street,
Dublin 7
T: 01 885 8674
F: 01 885 8336
E: twalsh@materprivate.ie

Mr. Ruaidhrí McVey
64 Eccles Street,
Dublin 7
T: 01 793 4601
F: 01 793 4602
E: mary.archbold@materprivate.ie

Mr. Kushal Chummun
Suite 12,
69 Eccles Street,
Dublin 7
T: 01 248 3161 / 089 611 1761
F: 01 686 5332
E: drkushal@materprivate.ie

Prof. Donal Brennan
Private Clinic,
60 Lower Mount Street,
Dublin 2
T: 087 142 9696
E: kathleen@profdbrennan.com

GYNAECOLOGY

Benign Gynaecology

- Abnormal Periods
- Post Menopausal Bleeding
- Pelvic Pain
- Prolapse
- Suspected Fibroids
- Suspected Ovarian Cyst
- Vaginal/Vulval Skin Problem
- Uterine Ablation

Gynaecological Oncology

- Ovarian Cancer
- Uterine Cancer
- Endometrial Cancer
- Cervical Cancer
- Vulvar Cancer

Robotic Surgery

- Hysterectomy

Colposcopy

- Colposcopy
- Cervix Assessment
- Biopsy
- LLETZ
- Laser
- Polypectomy
- Vaginal/Vulval Skin Problem
- Abnormal Bleeding/ Discharges

Laparoscopy

- Bleeding Clinic
- Hysteroscopy
- D&C

GYNAECOLOGY SERVICES

E-Referrals

E-Referral available. For queries call **1800 80 42 22** or email **ereferrals@materprivate.ie**

Open 8.00am - 5.00pm Monday to Friday

Insurance

Insurance cover helpline: **01 885 8856** or email **cover@materprivate.ie**

Open 8.00am - 5.00pm Monday to Friday

Self Pay

For Self Pay options call us on **1800 80 42 22** or email **ask@materprivate.ie**

Open 8.00am - 5.00pm Monday to Friday

If a patient has had smear tests, they should be brought to their appointment or sent with the letter of referral.

T: 01 885 8855
F: 01 885 8777
E: colposcopy@materprivate.ie

COLPOSCOPY CLINIC

Colposcopy Clinic,
Mater Private Hospital,
Eccles St.,
Dublin 7.

Mater Private Hospital
T: 01 885 8888 I **F:** 01 885 8541
E: info@materprivate.ie
W: www.materprivate.ie

Mater Private

Colposcopy Clinic - Referral Form*

Colposcopy Clinic, Mater Private Hospital, Eccles St., Dublin 7
T: 01 885 8855 | E: colposcopy@materprivate.ie

Consultant:

Next Available ☐ Mr. Tom Walsh ☐ Mr. Ruaidhrí McVey ☐ Mr. Kushal Chummun ☐

PRACTICE DETAILS

Name:

Address:

Tel:

Fax:

Referring GP signature:

PATIENT DETAILS

Name:

Address:

Tel:

Mobile:

Date of Birth:

PPS Number:

Mother's Maiden Name:

PROCEDURE

Cervical Check Smear Yes ◯ No ◯ Date Taken: ____ / ____ / ____

All referrals must have referring cytology smear result attached. Where this is not possible, please ensure patient has a copy and is advised to bring it to their appointment.

REFERRAL INDICATION

Abnormal Smear ◯ Suspicious Cervix ◯ Contact or Post Coital Bleeding ◯

Other:

Date of Smear:

Result of Smear:

Cytology Lab Requisition / Accession Number:

Reporting Lab:

Comments:

*E-Referral available
Date of revision: 20/03/19

Mater Private