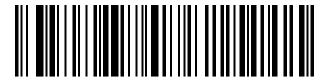
Eastern Health

Cancer Care Program

Provincial Cervical Screening Initiatives Program
Abnormal Pap Cytology – COLPOSCOPY REFERRAL FORM



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Instructions: Complete form and fax to Gynecologist – retain a copy for your records

Patient Information	**Physician Information (please use stamp)**
Name: ______________________________ HCN: ______________________________ Date of Birth: DD/MONTH/YYYY Age: _____ Address: ______________________________ ______________________________ Telephone: ______________________________	 ______________________________ Physician's Signature: ______________________ Date: DD/MONTH/YYYY Copy report to (please print): ______________________

Date of Referral: DD/MONTH/YYYY Gynecologist: ______________________________

Clinical Information

Reason for Consult:
- LSIL
- AGC
- HSIL
- ASC-H
- ASC-US
- Abnormal Appearance of Cervix
- Other: ______________________

Key:

ASCUS – Atypical Squamous Cells of Undetermined Significance
LSIL – Low Grade Squamous Intraepithelial Lesion
ASC-H – Atypical Squamous Cells cannot exclude HSIL
HSIL – High Grade Squamous Intraepithelial Lesion
AGC – Atypical Glandular Cells

Date of Abnormal Pap Test : DD/MONTH/YYYY

Pregnant Not Pregnant P ara G ravida A bortions

Significant Medical / Surgical History / Allergies:

List All Relevant Medications:

To be completed by Specialist

Date Requisition Received: DD/MONTH/YYYY Ordering Physician Notified: ☐ Phone ☐ Message ☐ Mail

Schedule appointment in: ☐ 2 weeks ☐ 4 weeks ☐ 6 weeks ☐ 12 weeks ☐ Other (specify) ______________

Gynecologist office to return to the referring physician and fax to the registry @ 752-6710.
Please keep a copy for your records.

CH-1069 2016/08