

COLPOSCOPY REFERRAL FORM



To: _____ Colposcopy Clinic

Date:

WOMAN'S DETAILS

Name

Address

.....

Previous Address

(if relevant)

Contact Tel. Number

DOB

PPS Number (ID/MR#)

CSP ID

Mother's Maiden Name

Surname at Birth

CervicalCheck Smear Yes No

Referral Smear Details Date of Smear:Result of Smear:

(Please attach a copy of the referring cytology smear result form as necessary) Cytology Lab Requisition/Accession Number:

Reporting Lab:

Past Smear History

.....

.....

Previous Colposcopy Yes No Where:

Previous Treatment

Doctors Comments

.....

.....

.....

Referring Doctors Stamp: