CervicalCheck
AN CLÁR NÁISIÚNTA SCAGTHÁSTÁLA CEIRBHEACS
THE NATIONAL CERVICAL SCREENING PROGRAMME

Cervical Screening Form

Incomplete forms may be returned.
Please verify with the client that all details on the form are correct.
Once verified please remove the vial number label from the sample vial and attach to the form.

Vial number label: Detach from the vial and place here

Please use every effort to provide woman's PPSN

Personal Public Service Number (Numbers / Letters)

CSP ID

Hospital Number (if applicable)

Date of Birth (Day / Month / Year)

Individual Health Identifier (IHI):

Surname Use BLOCK CAPITALS when filling in your details

First Name

Middle Name

To ensure accurate identification of the woman, please complete this section in its entirety.

Surname at Birth

Mother's Maiden Name

Postal Address for Correspondence

Eircode:

Contact Telephone No.

Please check that your details abov

Ensure that the woman's consent is recorded here (signature, witnessed mark, verbal with note of doctor / nurse).

Samples submitted with forms without consent **will not** be processed.

Doctor / Nurse

Doctor / Nurse name:
Practice / Clinic:
Address:

Clearly write the name and address of the doctor / nurse who took the test.

Write the MCRN / NMBI number here.

Doctor / Nurse ID: (MCRN or NMBI No.)

Telephone No.:

Document MCRN of contract holder with Cervical Check

Clinically Responsible Doctor ID or Clinic ID: (MCRN)

Date of Test (Day / Month / Year)

LMP (Day / Month / Year)

Relevant Clinical Details (please tick as appropriate)

Tick only clinically appropriate boxes.

OCP/Hormones/HRT ☐ IUCD ☐ Post Menopausal ☐
HPV Vaccinated ☐ Post Colposcopy Smear ☐ Sub-total / Total Hysterectomy ☐
Pre/Post Transplant ☐ Dialysis ☐ DES ☐ CD4i ☐
Post-coital bleeding ☐ Post-menopausal bleeding ☐

Sample Site: Cervix ☐ Vault (post total hysterectomy) ☐

Where the cervix is present smeartaker must visualise the entire cervix and sample it correctly with 5 x 360° rotations of the sampler. Submission of the sample is confirmation that this has been done

Identify the sample site.

Screening History

Lab Name	Test Date	Cytology result	HPV result

	Date	Procedure	Result

LABORATORY USE ONLY

Date Received in Laboratory (Day / Month / Year)

Accession Specimen Number:

Barcode

TZ Cells Yes ☐ No ☐

Final Report

Management Recommended

1° 2°

Path

Date Reported (Day / Month / Year)

Signature (Day / Month / Year)

CS/F/LAB-2 Rev 16