



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.

V	/ial Number:

A. Client's Details	C. Dataile of Contracted Poster or Contracted Clinic
	C. Details of Contracted Doctor or Contracted Clinic
Personal Public Service Number	Medical Council Registration Number of contracted doctor:
CSP ID	OR Clinic code: (CLIN COLP GYN PPCC STI or ONC)
Hospital Number (if applicable)	Contracted Doctor or Clinic's Name: Address:
Date of Birth	
Surname Use BLOCK CAPITALS	
	Telephone No.
First Name	D Sampletaker's details
	D. Sampletaker's details
Middle Name	MCRN or NMBI
	Sampletaker's name:
Surname at Birth	E. Cervical Screening Test Information
Mother's Maiden Name	Date of Test
	Sample site
	Cervix Vault (post total hysterectomy)
Full Postal Address (The result letter will be sent to this address)	Where the cervix is present, the sampletaker must visualise the entire cervix and sample it correctly with 5 x 360° rotations of the broom/brush. Submission of the sample is
	confirmation that this has been done.
	F. Relevant clinical details
	Day Month Year
	LMP
Eircode:	OCP/Hormones/HRT Pre/Post Transplant Post-coital bleeding
	IUCD Dialysis Post-menopausal bleeding
Contact Telephone No.	Post-menopausal HIV Positive Sub-total Hysterectomy
	Total Hysterectomy
B. Consent	G. Screening and Treatment History
I have checked that all of my details above are correct.	
I have read and understood the information given to me.	
I consent to take part in CervicalCheck.	
Client's Signature:	
CervicalCheck does not accept third party consent for a client unless a family member or carer have specific legal authority to do so.	
LABOI	RATORY USE ONLY
Date Received in Laboratory Month Year	
Accession number	Path Management recommendation
1º 2º	
TZ Cells Yes No No	
Date Reported	Signature