This section is not for GP practices

Detach the vial number label from the vial and place it here

Please use every effort to provide the PPSN

Complete MCRN of CervicalCheck CONTRACT HOLDER

Complete name, address & phone number of CervicalCheck CONTRACT HOLDER

To ensure accurate identification, please confirm details with the woman and complete this section in its entirety

Complete Section D with the details of the HEALTH PROFESSIONAL WHO TOOK THE TEST

Identify the sample site

Tick ONLY clinically appropriate boxes

Ensure that consent is recorded here (signature, witnessed mark, verbal with note of doctor /nurse)

Incomplete forms m
Please verify with th the form are correct.
Once verified pleas abel from the sample vi and

A. Client's Details

Personal Public Service Number (Number / Letters)

CSP ID

Hospital Number (if applicable)

Date of Birth (Day / Month / Year)

Surname Use BLOCK CAPITAL

First Name

Middle Name

Surname at Birth

Mother's Maiden Name

Full Postal Address (The result letter will be sent to this address)

Eircode:

Contact Telephone No.

C. Detail ...tracted Clinic

Medical Council Registration Number of contracted doctor:

OR

Clinic code: (CLIN COLP GYN PPCC STI or ONC)

Contracted Doctor or Clinic's Name:

Address:

Telephone No.

D. Sampletaker's d

MCRN or NMBI

Sampletaker's name:

E. Cervical Screening Test Information

Date of Test (Day / Month / Year)

Sample site

☐ Cervix ☐ Vault (post total hysterectomy)

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

LMP (Day / Month / Year)

- ☐ OCP/Hormones/HRT
- ☐ IUCD
- ☐ Post-menopausal
- ☐ Pre/Post Transplant
- ☐ Dialysis
- ☐ HIV Positive
- ☐ Post-coital bleeding
- ☐ Post-menopausal bleeding
- ☐ Sub-total Hysterectomy
- ☐ Total Hysterectomy

B. Consent

I have checked that all of
I have read and understood t
I consent to take part in CervicalCh

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.

G. Screening and Treatment History

LABORATORY USE ONLY

Date Received in Laboratory (Day / Month / Year)

Accession number

1° 2°

TZ Cells Yes ☐ No ☐

Path

Management recommendation

Date Reported

Signature

CS/F/LAB-2 Rev 17