

**Colposcopy Clinic Referral Form**  
Booking **TELEPHONE**: 250-370-8884 **FAX**: 250-519-1551  
RJH D&T Building  
1952 Bay Street  
Victoria, BC V8R 1J8

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| **Patient Information:**  **Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Preferred Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | **Medical Record Number:** |
|  |
| **Referring Physician/Billing Number:** | | **Physician Phone/Fax Number:** | | | **Family Physician (if different):** |
| **Financial Responsibility**  🗆 BC Resident – MSP 🗆 Other Province \_\_\_\_\_\_\_\_\_\_\_ 🗆 uninsured Services  🗆 Non-Resident Canada 🗆 Self 🗆 Armed Forces | | | | | |
| **Cytology Result**   * Unsatisfactory   Squamous   * ASC-US * LSIL (mild) * ASC-H * HSIL (Mod) * HSIL (Marked) * Carcinoma in situ * Malignant   Glandular   * AGC NOS * AGC Neoplastic * AIS * Malignant   **\* ALL REFERALS MUST INCLUDE CYTOLOGY RESULT** | **Other Reason for Referral**   * Clinical abnormality of the Cervix * DES * Other \_\_\_\_\_\_\_\_\_\_\_   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Cytology result out of Province?  **YES NO** | | **Procedure Requested**     * Colposcopy * Repeat colposcopy * LEEP * Follow-up * Vulvoscopy | | **Preferred Physician**   * First Available * Dr Cohen * Dr Hancock * Dr Hunt * Dr Mazgani * Dr Quinlan |
| **Pregnant**  YES NO    Weeks \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Allergies/Sensitivities**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | **Special Needs**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Appointment Date/Time** | | | | | **Patient Notified**  YES NO |
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