

**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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