island health

Colposcopy Clinic Referral Form

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

Patient Information:

Name: _____

DOB: _____

Preferred Name: _____

PHN: _____

Medical Record Number

Telephone

Referring Physician/Billing Number	**Physician Phone/Fax Number**	**Family Physician (if different)**

Financial Responsibility

- ○ BC Resident – MSP
- ○ Non-Resident Canada
- □ Other Province _____
- □ Self
- □ uninsured Services
- □ Armed Forces

Cytology Result

- ○ Unsatisfactory

Squamous

- ○ ASC-US
- ○ LSIL (Mild)
- ○ ASC-H
- ○ HSIL (Mod)
- ○ HSIL (Marked)
- ○ 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
- ○ LEEP
- ○ Follow-up

Previous Visit to Clinic With

- ○ Dr Cohen
- ○ Dr Hancock
- ○ Dr Hunt
- ○ Dr Mazgani
- ○ Dr Quinlan

Pregnant YES NO

Weeks _____

Allergies/Sensitivities NONE

_____
_____
_____
_____

Special Needs

_____
_____
_____
_____

Appointment Date/Time	**Patient Notified** YES NO

June 2016